

AMP Montana Appendices		
Appendix Number	Title	Referenced or Requested
Appendix 1	Children's Mental Health Eligibility Administrative Rule #37-89-103	Part A: Question 1, Page 1
Appendix 2	Youth Residential Treatment: Admission Criteria for PRTF	Part A: Question 1, Page 1
Appendix 3	Children's System of Care Legislation	Part A: Question 8, Page 5 Part B: Question 2, Page 10
Appendix 4	Introduction to Kids Management Authorities	Part A: Question 11, Page 6
Appendix 5	Public Participation – Administrative Rules of Montana 2-3-103 MCA	Part B: Question 2, Page 10
Appendix 6	Montana's Level of Care Assessment: Child Behavior Checklist (CBCL)	Part B: Question 4, Page 12 Part B: Question 5, Page 14
Appendix 7	Yellowstone County KMA Letter of Commitment and Memorandum of Understanding	Part B: Question 4, Page 12
Appendix 8	Administrative Rules of Montana: 37.85.401 – 402 Provider Participation	Part B: Question 7, Page 15
Appendix 9	Letters of Commitment and Support	Part B: Question 11, Page 18
Appendix 10	Statement of Assurance	Part B: Question 12, Page 18
Appendix 11	Assessment Tools: BERS, YSS and GAIN	Part D: Question 1, Page 22
Appendix 12	Discussion of Reliability, Validity and Appropriateness for Assessment Tools	Part D: Question 1, Page 22
Appendix 13	Proposed Demographic, Healthcare and Functional Outcome Variables	Requested in Invitation to Apply, Page 26
Appendix 14	Identification, Recruitment and Retention Flow Chart	Part B: Page 11
Appendix 15	Reporting Assurances	Requested in Invitation to Apply, Page 35
Appendix 16	Documentation of Benefit as Part of State Plan	Requested in Invitation to Apply, Pages 8 - 9

Appendix 1:
Children's Mental Health Eligibility
Administrative Rule #37-89-103

Referenced:
Part A Systems Assessment
Question 1, Page 1

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 89

MENTAL HEALTH SERVICES

Subchapter 1

Mental Health Services Plan

Rules 01 and 02 reserved

Rule 37.89.103 Mental Health Services Plan, Definitions

Rules 04 and 05 reserved

37.89.106 Mental Health Services Plan, Member
Eligibility

Rules 07 through 13 reserved

(7) "Federal poverty level" or "FPL" means the 2000 poverty guidelines for the 48 contiguous states and the District of Columbia as published under the "Annual Update of the HHS Poverty Guidelines" in the Federal Register on February 15, 2000 and subsequent annual updates.

(8) "Medically necessary" is defined as provided in ARM 37.82.102.

(9) "Member" means, with respect to the plan, an individual (or, as the context allows, the parent or guardian of the individual) eligible, according to the requirements of ARM 37.89.106, for services and receiving or attempting to receive services under the plan.

(10) "Mental health services plan" or "plan" means the mental health services program established in this subchapter.

(11) "Mental health services" means services covered as specified in ARM 37.89.114 when provided with respect to a covered diagnosis.

(12) "Provider" means a person or entity that has enrolled and entered into a provider agreement with the department in accordance with the requirements of ARM 37.89.115 to provide mental health services to members.

(13) "Provider agreement" means the written enrollment agreement entered into between the department and a person or entity to provide mental health services to recipients.

(14) "Serious emotional disturbance (SED)" means with respect to a youth between the ages of six and 17 years that the youth meets the following requirements of (14)(a) and either (14)(b) or (14)(c):

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

(i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);

(ii) oppositional defiant disorder (313.81);

(iii) autistic disorder (299.00);

(iv) pervasive developmental disorder not otherwise specified (299.80);

(v) asperger's disorder (299.80);

(vi) separation anxiety disorder (309.21);

(vii) reactive attachment disorder of infancy or early childhood (313.89);

(viii) schizo affective disorder (295.70);

(ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

- (x) obsessive-compulsive disorder (300.3);
- (xi) dysthymic disorder (300.4);
- (xii) cyclothymic disorder (301.13);
- (xiii) generalized anxiety disorder (overanxious disorder) (300.02);
- (xiv) posttraumatic stress disorder (chronic) (309.81);
- (xv) dissociative identity disorder (300.14);
- (xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
- (xvii) anorexia nervosa (severe) (307.1);
- (xviii) bulimia nervosa (severe) (307.51);
- (xix) intermittent explosive disorder (312.34); and
- (xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

(b) As a result of the youth's diagnosis determined in (14)(a) and for a period of at least six months, or for a predictable period over six months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

- (i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;

- (ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;

- (iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;

- (iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;

- (v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or

- (vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous six months:

- (i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;

(iii) the juvenile correctional system, due to the diagnosis determined in (14)(a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or

(iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least six months or is predicted to continue for a period of at least six months, as manifested by one or more of the following:

(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;

(ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;

(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or

(vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers.

(15) "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (15)(a), (b) or (c). The person must also meet the requirements of (15)(d). The person:

(a) has been involuntarily hospitalized at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Springs campus) at least once;

(b) has a DSM-IV diagnosis with a severity specifier of moderate or severe of:

- (i) schizophrenic disorder (295);
- (ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);
- (iii) mood disorder (293.83, 296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);
- (iv) amnestic disorder (294.0, 294.8);
- (v) disorder due to a general medical condition (310.1);
- (vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
- (vii) anxiety disorder (300.01, 300.21, 300.3); or

(c) has a DSM-IV diagnosis with a severity specifier of moderate or severe of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least six months or for an obviously predictable period over six months; and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:

(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the social security administration;

(iv) the person maintains a living arrangement only with ongoing supervision, is homeless or is at imminent risk of homelessness due to mental illness; or

(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes increased symptoms of psychosis, self-injury, suicidal or homicidal intent or psychiatric hospitalization.

(16) "Total family income" means the total annual gross cash receipts, as defined by the bureau of the census and cited in the "Annual Update of the HHS Poverty Guidelines" promulgated each year by the United States Office of Management and Budget, of all members of a family. Regular and continuing sources of income will be appropriately annualized for purposes of determining the annual income level. Extraordinary and nonrecurring income will be considered only for the 12 month period following receipt.

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

(a) Total family income does not include:

(i) money received as assets drawn down such as withdrawals from a bank or the sale of a house or a car; or

(ii) income tax refunds, gifts, loans, one-time insurance payments, except as beneficiary of a life insurance policy, or compensation for injury.

(17) "Youth" means an individual who has not yet attained 18 years of age, except that for purposes of the definition of serious emotional disturbance, "youth" may include an individual who has not yet attained 21 years of age if the person is enrolled in a full-time special education program.

(18) The department hereby adopts and incorporates by reference the ICD-9-CM diagnosis codes with meanings found in the St. Anthony's ICD-9-CM Code Book (1998) effective October 1, 1998 through September 30, 1999, published by St. Anthony Publishing. The department also hereby adopts and incorporates by reference the DSM-IV diagnosis codes with meanings found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), published by the American Psychiatric Association of Washington, DC. These systems of coding provide the codes and meanings of the diagnostic terms commonly used by treating professionals and are incorporated herein in order to provide common references for purposes of the provision of services through the mental health services plan. Copies of applicable portions of the ICD-9-CM and the DSM-IV may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905. (History: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-21-703, MCA; IMP, Sec. 41-3-1103, 52-1-103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-21-139, 53-21-202 and 53-21-701, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 308, Eff. 2/12/99; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS & AMD, from SRS, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 989, Eff. 6/8/01; EMERG, AMD, 2002 MAR p. 3417, Eff. 12/1/02; AMD, 2003 MAR p. 653, Eff. 3/28/03; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

Rules 04 and 05 reserved

37.89.106 MENTAL HEALTH SERVICES PLAN, MEMBER ELIGIBILITY

(1) An individual is eligible for covered services under the plan if:

(a) the individual is a youth with a serious emotional disturbance or an adult with a severe disabling mental illness; and the family of which the individual is a member has a total family income, without regard to other family resources, at or below 150% of the most recently published federal poverty level (FPL);

(b) the individual has been denied medicaid eligibility, is ineligible for medicaid by virtue of being a patient in an institution for mental diseases, or has applied for medicaid and the application is pending. An individual who meets medicaid eligibility requirements but does not apply for medicaid is not eligible to receive services under the plan;

(c) the individual is under the age of 19 years and the individual has been denied enrollment in Montana children's health insurance program (CHIP), as established in ARM Title 37, chapter 79;

(d) the individual is an adolescent who has met the eligibility requirements of the plan as a youth with serious emotional disturbance, but who will not meet the eligibility requirements of the plan as an adult with severe and disabling mental illness. The individual may continue to be eligible as an adolescent for the purpose of transition to independent living until the age of 21, provided the individual continues to meet income requirements; and

(e) the total number of children and the total number of adults who can be eligible for MHSP at any time is within the limits set by the department as provided in (6) of this rule.

(2) If a person who is determined eligible for the plan based upon a pending medicaid application is later determined to be eligible for medicaid:

(a) any payment received by the provider under the plan for services provided during the effective period of medicaid eligibility must be refunded to the department; and

(b) all services provided to the individual during the effective period of medicaid eligibility may be billed to medicaid according to applicable medicaid requirements.

Appendix 2:
Admission Criteria for PRTF

Referenced:
Part A Systems Assessment
Question 1, Page 1

YOUTH RESIDENTIAL TREATMENT CLINICAL MANAGEMENT GUIDELINES

First Health Services of Montana will employ the use of *the Montana Medicaid and Clinical Management Guidelines* strictly as guidelines. This practical application, coupled with professional judgement based on clinical expertise and national best practices, will enhance the rendering of authorization decisions for the child/adolescent age populations.

Psychiatric residential treatment services are provided 24 hours per day, 7 days per week, in an appropriately licensed facility staffed by a multi-disciplinary team of licensed and credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for the restrictive level of care necessary for the well being and safety of the patient and others.

Patients are evaluated by a physician who documents the patient's clinical history and the results of the professional's examination. The course of treatment and the patient's response to the treatment efforts must be thoroughly documented in records consistent with the standards of JCAHO and/or state licensing requirements. Records must reflect the initiation of discharge planning at the time of admission.

Admission Criteria

A covered DSM-IV diagnosis as the principal diagnosis and a determination that the youth has a serious emotional disturbance. In addition, all of the following must be met:

1. Symptoms or functional impairments of the individual's emotional disturbance are of a severe and persistent nature and require 24-hour treatment under the direction of a physician.
2. Less restrictive services are documented to be insufficient to meet the individual's severe and persistent clinical and treatment needs. The prognosis for treatment at this inpatient level of care can reasonably be expected to improve the individual's condition or prevent further regression based upon the physician's evaluation.
3. The treatment plan includes the active participation of the parent(s) or legal guardian and all active pre-admission caregivers.
4. If a compromised academic performance is part of the clinical presentation, an individualized educational plan (IEP) is in place from the individual's school district, **OR** the treatment plan includes a referral for an IEP in writing to the home district.
5. A comprehensive discharge plan and estimated length of stay will be developed upon admission identifying appropriate services to be provided necessary to meet the individual's needs at a less restrictive level of care.

Continued Treatment Criteria (must meet all of the following)

1. The individual continues to meet all Admission Criteria.
2. The individual was seen and evaluated by physician within 24 hours of admission. The medical record documents progress toward identified treatment goals and the reasonable

likelihood of continued progress as indicated by objective behavioral measurements of improvement.

3. The individual and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the plan of care.
4. Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The Treatment Team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.

Discharge Criteria (must meet at least one of the following)

1. Treatment of the individual's emotional disturbance no longer requires 24-hour direction by a physician; or
2. The individual's clinical and treatment needs can be met in a less restrictive setting; or
3. The Individual Treatment Plan goals have been sufficiently met such that the individual no longer requires this level of care; or
4. The beneficiary voluntarily leaves the program or the beneficiary's parent or legal guardian removes them from the program.

Appendix 3:
Children's Systems of Care Legislation
52-2-301 – 52-2-304 MCA

Referenced:
Part A Systems Assessment
Question 8: Page 5
Part B Development Plan
Question 2: Page 11

52-2-301. State policy. The legislature declares that it is the policy of this state:

(1) to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available;

(2) to serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development;

(3) to serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort;

(4) to provide integrated services to high-risk children with multiagency service needs;

(5) to contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements;

(6) to increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children; and

(7) to prioritize available resources for meeting the essential needs of high-risk children with multiagency service needs.

History: En. Sec. 2, Ch. 324, L. 1993; amd. Sec. 1, Ch. 118, L. 2003.

52-2-302. Definitions. The following definitions apply to this part:

(1) (a) "High-risk child with multiagency service needs" means a child under 18 years of age who is seriously emotionally disturbed, who is placed or who imminently may be placed in an out-of-home setting, and who has a need for collaboration from more than one state agency in order to address the child's needs.

(b) The term does not include a child incarcerated in a state youth correctional facility.

(2) "Least restrictive and most appropriate setting" means a setting in which a high-risk child with multiagency service needs is served:

(a) within the child's family or community; or

(b) outside the child's family or community where the needed services are not available within the child's family or community and where the setting is determined to be the most appropriate alternative setting based on:

(i) the safety of the child and others;

(ii) ethnic and cultural norms;

(iii) preservation of the family;

(iv) services needed by the child and the family;

(v) the geographic proximity to the child's family and community if proximity is important to the child's treatment.

(3) "Provider" means an agency of state or local government, a person, or a program authorized to provide treatment or services to a high-risk child with multiagency service needs who is suffering from mental, behavioral, or emotional disorders.

(4) "Services" has the meaning as defined in [52-2-202](#).

(5) "System of care" means an integrated service support system that:

(a) emphasizes the strengths of the child and the child's family;

(b) is comprehensive and individualized; and

- (c) provides for:
 - (i) culturally competent and developmentally appropriate services in the least restrictive and most appropriate setting;
 - (ii) full involvement of families and providers as partners;
 - (iii) interagency collaboration; and
 - (iv) unified care and treatment planning at the individual child level.

History: En. Sec. 1, Ch. 324, L. 1993; amd. Sec. 2, Ch. 118, L. 2003.

52-2-303. Children's system of care planning committee -- membership -- administration. (1) There is a children's system of care planning committee.

- (2) The committee is composed of the following members:
 - (a) an appointee of the director of the department of public health and human services representing the mental health program;
 - (b) an appointee of the director of the department of public health and human services representing child protective services;
 - (c) an appointee of the director of the department of public health and human services representing the developmental disability program;
 - (d) an appointee of the director of the department of public health and human services representing the chemical dependency treatment program;
 - (e) other appointees considered appropriate by the director of the department of public health and human services who may be representatives of families of high-risk children with multiagency service needs, service providers, or other interested persons or governmental agencies;
 - (f) an appointee of the superintendent of public instruction representing education;
 - (g) an appointee of the director of the department of corrections;
 - (h) an appointee of the youth justice council of the board of crime control; and
 - (i) an appointee of the supreme court representing the youth courts.
- (3) The committee is attached to the department of public health and human services for administrative purposes only as provided in [2-15-121](#).
- (4) Except as provided in this section, the committee must be administered in accordance with [2-15-122](#).

History: En. Sec. 3, Ch. 324, L. 1993; amd. Sec. 148, Ch. 418, L. 1995; amd. Sec. 342, Ch. 546, L. 1995; amd. Sec. 3, Ch. 118, L. 2003.

52-2-304. Committee duties. (1) The committee established in [52-2-303](#) shall, to the extent possible within existing resources:

- (a) develop policies aimed at eliminating or reducing barriers to the implementation of a system of care;
- (b) promote the development of an in-state quality array of core services in order to assist in returning high-risk children with multiagency service needs from out-of-state placements, limiting and preventing the placement of high-risk children with multiagency service needs out of state, and maintaining high-risk children with multiagency service needs within the least restrictive and most appropriate setting;
- (c) advise local agencies to ensure that the agencies comply with applicable statutes, administrative rules, and department policy in committing funds and resources for the implementation of unified plans of care for high-risk children with multiagency service needs

and in making any determination that a high-risk child with multiagency service needs cannot be served by an in-state provider;

(d) encourage the development of local interagency teams with participation from representatives from child serving agencies who are authorized to commit resources and make decisions on behalf of the agency represented;

(e) specify outcome indicators and measures to evaluate the effectiveness of the system of care;

(f) develop mechanisms to elicit meaningful participation from parents, family members, and youth who are currently being served or who have been served in the children's system of care; and

(g) take into consideration the policies, plans, and budget developed by any service area authority provided for in [53-21-1006](#).

(2) The committee shall coordinate responsibility for the development of a stable system of care for high-risk children with multiagency service needs that may include, as appropriate within existing resources:

(a) pooling funding from federal, state, and local sources to maximize the most cost-effective use of funds to provide services in the least restrictive and most appropriate setting to high-risk children with multiagency service needs;

(b) applying for federal waivers and grants to improve the delivery of integrated services to high-risk children with multiagency service needs;

(c) providing for multiagency data collection and for analysis relevant to the creation of an accurate profile of the state's high-risk children with multiagency service needs in order to provide for the use of services based on client needs and outcomes and use of the analysis in the decisionmaking process;

(d) developing mechanisms for the pooling of human and fiscal resources; and

(e) providing training and technical assistance, as funds permit, at the local level regarding governance, development of a system of care, and delivery of integrated multiagency children's services.

(3) (a) In order to maximize integration and minimize duplication, the local interagency team, provided for in subsection (1)(d), may be facilitated in conjunction with an existing statutory team for providing youth services, including:

(i) a child protective team as provided for in [41-3-108](#);

(ii) a youth placement committee as provided for in [41-5-121](#) and [41-5-122](#);

(iii) a county interdisciplinary child information team or an auxiliary team as provided for in [52-2-211](#);

(iv) a foster care review committee as provided for in [41-3-115](#);

(v) a local citizen review board as provided for in [41-3-1003](#); and

(vi) a local advisory council as provided for in [53-21-702](#).

(b) If the local interagency team decides to coordinate and consolidate statutory teams, it shall ensure that all state and federal rules, laws, and policies required of the individual statutory teams are fulfilled.

History: En. Sec. 4, Ch. 324, L. 1993; amd. Sec. 4, Ch. 118, L. 2003; amd. Sec. 63, Ch. 130, L. 2005; amd. Sec. 1, Ch. 200, L. 2005.

Appendix 4:
An Introduction to Kids Management Authorities

Referenced:
Part A Systems Assessment
Question 11, Page 6

An Introduction to Montana's Kids Management Authorities (KMAs)

Background:

During the 2003 Legislative Session, the Legislature continued the work of Senate Bill 454, (Title 52, Chapter 2, Part 3), Montana's first multi-agency children's bill, in the form of Senate Bill 94. This statute charges the State of Montana, under the guidance of the Department of Public Health and Human Services (DPHHS), with the creation of a system of care. The system includes both an infrastructure and a comprehensive continuum of services for Montana's high-risk youth and their families, who are currently served by multiple agencies.

Senate Bill 94 also provided for the establishment of the Children's System of Care Planning Committee (SOC Committee), which coordinates the development of the State's system of care. This committee's membership is comprised of representatives from:

- State agencies which provide services to children;
- Parents
- Providers
- Native Americans; and
- Advocates.

The State, through the SOC Committee, provides leadership in the development of the system of care and Kids Management Authorities (KMAs) within Montana's communities.

This system will be designed through the efforts of the State and local communities. The KMA is the infrastructure upon which the State system of care will be built. The State is committed to this approach and has committed a limited amount of financial resources toward helping communities establish KMAs. The State, in partnership with the community, shares in the responsibility to ensure all KMA Community Team members are working together toward common goals and objectives.

The State also supports the development of KMAs on Montana's reservations. Because these organizations will be sensitive to the cultural structure of the respective reservations, this may result in a KMA that appears somewhat different than a non-reservation KMA. However, adherence to the basic principles and values of a system of care would still be foremost in their creation.

The KMA is built upon the values and principles of a system of care (articulated by Stroul and Friedman, *"Building Systems of Care - A Primer"*, 2002):

- *A system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.*
- *The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.*
- *The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they service.*

How it works:

The KMA is the infrastructure that supports a comprehensive and statewide system of care. The KMA has two primary functions, development of a continuum of care within their respective community, and case planning and coordination for individual youth with SED and their families. This system of care is child-focused and family-driven. It also provides wrap-around services to youth and their families within their community. Characteristics of the system include:

- A service design and delivery based upon the strengths of the youth, family, and community;
- An awareness of familial, cultural, racial, and ethnic differences;
- A focus on prevention/early intervention;
- An orientation toward outcome/results; and
- A funding mechanism that blends available resources.

The SOC Committee, together with community KMAs, identifies training needs, service gaps, funding, and other barriers to service delivery. Together, they implement responses to identified needs.

Funding:

In order for KMAs to be sustained over time, funding for operations must come from a variety of sources. Ideally, this funding should be flexible and not connected to any one category. The use of funds should be related to best practice principles and serve the needs of youth and their families.

Administrative functions related to KMAs will need assistance, including financial support. The DPHHS Health Resources Division's Children's Mental Health Bureau is committed to identifying funding to assist local KMAs.

Who KMAs help:

KMAs are geared primarily toward children with serious emotional disturbances who are at risk of, or currently residing in, out-of-home placement. These youths are typically served by many agencies.

The primary population also includes children under the age of six. The multiple treatment needs of these youths evolve and change over time.

Each KMA has the discretion to serve a secondary population of youth based on its ability to do so.

KMA Community Design Team Membership:

The KMA Community Team is a multi-agency community organization comprised of:

- Parents;
- Youth;
- State agencies serving children, including the DPHHS divisions of Child and Family Services, Developmental Disabilities, and Health Resources, as well as the Department of Corrections and Youth Court;
- Other programs that serve Montana's youth, including First Health;
- Tribal representatives;
- Providers; and
- Advocates.

KMA Community Team representatives will have the authority to make decisions about and allocate money for services to youth and their families. When the KMA is serving a Tribal community, Tribal representatives must have the opportunity to participate as full members in the KMA.

Because KMAs are local organizations, Tribal communities may wish to develop them respective to their communities as an option to joining off-reservation KMAs. To ensure coordination with Service Area Authority (SAA) activities, a representative of the regional SAA must have the opportunity to participate as a full member in the KMA. The KMA may add representatives of other community organizations and leaders as appropriate.

KMA Community Team Goals and Tasks:

Goal 1: Design, implement, and support a community-based system of care for youths and their families.

The KMA will accomplish this goal in two ways: As leaders within their communities, Community Team members identify gaps in the community system and develop needed resources for youth and their families. As the Youth

Coordination Team, the KMA plans, coordinates, and delivers services to individual youth and their families within communities.

Task 1: Build consensus among agencies in order to create a community focused on improving the lives of children and their families.

Task 2: Identify and/or create funding sources. This includes exploring various funding avenues, from fund raising to grant granting, as well as blending available monies in creative and flexible ways.

Task 3. Conduct broad-based community assessments; profile local gaps, strengths, and assets; and locate and/or establish needed resources within the community.

Task 4. Develop policies and procedures to ensure a unified and comprehensive delivery of services.

Task 5. Design data gathering methods, processes, and distribute data about all aspects of the needs of youth with serious emotional disturbance and their families to the State, community, providers, and the consumer.

Task 6. Track and monitor outcomes, collect data, and analyze information to support learning and decision-making.

Task 7. Serve as a gateway to the SED waiver established by the State.

Goal 2: Integrating wrap-around philosophy into service delivery.

Task 1. Develop mechanisms at the local level that ensure providers adhere to the basic principles of wrap-around philosophy as they implement plans developed by the Individual Care Coordination Team. This philosophy emphasizes that services will be delivered in full partnership with families, stressing the importance of outcomes and cultural competence.

Goal 3: Reduce the stigma surrounding serious emotional disturbances for individuals and their families.

Task 1. Serve as local educators regarding the comprehensive treatment process and needs of youth with serious mental illnesses and their families.

Task 2. Establish and implement a plan for identifying and training parents and youth to be active in policy-making functions of the KMA and the system of care. Provide training to parents and youth to serve as mentors to other parents, and formalize their roles as parent/youth advocates.

Goal 4: Partner with the State to provide information on the system's needs and development, participate in policy development, and educate legislators on the needs of youth with serious emotional disturbances and the impact on their families.

Task 1: Identify barriers to the delivery of services and communicate to the SOC's committee.

Task 2: Assist in adjusting policies, procedures, administrative rules, and protocols for the service system to accommodate integrated programming and a seamless continuum of care for youth.

Task 3. Serve as consultants/mentors by sharing ideas, experiences, and expertise with other communities.

KMA Individual Care Coordination Team Membership:

The Youth Care Coordination Team at a minimum consists of representatives from all State agencies that serve children. These representatives must have the authority to make fiscal decisions regarding services to youth and their families. Membership is specific to the youth and family being served. The parent is the key member and participant of this team, unless parental rights have been modified. The team leader for each meeting is established by the team.

In addition to these members, the youth's case manager, parole officer, and/or social worker are expected to participate in the planning, monitoring, and delivery of services developed by the Team.

Membership on the team may vary according to the needs of the child and his family, and may include:

- Caregivers;
- Mentors;
- Neighbors;
- Clinical consultants;
- Legal advocates;
- Agency representatives;
- School personnel;
- Tribal representatives;
- First Health; and
- Other individuals who best know the strengths and needs of the youth, family, and service system.

The team serves as the means by which all efforts and resources of the community and involved parties are organized and delivered in a comprehensive and unified way.

KMA Individual Care Coordination Team Goal/Tasks:

Goal: The Youth Coordination Team enhances access to an integrated, wrap-around system of services designed for the individual needs of children with serious emotional disturbances and their families.

Task 1: Meet as needed to coordinate service planning, delivery, and funding.

Task 2: Monitor service delivery for high-cost youth.

Operations:

The KMA's Community Team conducts its meetings on a regular basis at a place and time designated by its members. These meetings are focused on system issues and service continuum development. They are open to the public, except when specific cases are part of the discussion.

Youth Coordination Team meetings are limited to those individuals who need to be involved in the delivery of services or whose attendance has been requested by the youth and/or family. These meetings must adhere to HIPAA confidentiality requirements. The KMA will develop protocols for referrals based on individual community needs. Children may access the KMA by an agency, through a case manager, or by a member of the KMA team.

Under Montana law, KMAs meet the definition of a County Interdisciplinary Child Information Team and must abide by all related confidentiality standards. All agencies committed to being a part of the KMA must sign a Memorandum of Understanding and comply with HIPAA regulations.

The Benefits of a KMA:

The benefits of having a KMA for high-risk youth, their families, and their communities are many, including:

- Children and their families have a unified plan of care, which minimizes confusion;
- Children and their parents are the most significant members of the Youth Coordination Team;
- Children and their families experience fewer crises;
- Children receive the majority of their care in family-centered, community-based settings;
- Children are more competent at home and at school;
- Parents have a better support system; and
- Parents are more satisfied and empowered in the design and delivery of services for their children.

- Services and treatment is based on the strengths of the youth and family.

Its advantages for agencies include:

- Increased trust regarding the planning and delivery of services to youth and their families;
- Easier information sharing among agencies;
- Reduced paper work and administration;
- Unification in the care plan for children and families with multi-agency needs;
- Reduced pressure on partner agencies' budgets, allowing for the transfer of resources to more preventative and less costly services.

Its advantages for the community include:

- Ownership and accountability for children and their families' development in the community;
- Involvement in a creative process of providing services to youth and their families;
- An awareness and utilization of informal community supports for children and their families; and
- An increased sense of satisfaction regarding the accountability and effectiveness of services provided to youth and their families.

Challenges of a KMA:

While there are many benefits surrounding the establishment of KMAs, they are equally accompanied by challenges for participants, including:

- Resisting change, which may require altering the manner in which decisions are made;
- Sharing in the process of service planning;
- Changing the philosophy about how those decisions are made (family driven vs. agency driven), which could be met with some resistance;
- Accepting the values and philosophy of a KMA among agencies, which could be met with resistance;
- Evidence-based service development and delivery may be new challenges for the system of care;
- Funding source restrictions;
- Lack of appropriate services (such as family focused services and community based services); and
- Lack of provider networks.

To learn more:

Please see attached System of Care Map for local contact or contact Pete Surdock, Chief of the DPHHS Children's Mental Health Bureau, at (406) 444-1290, or e-mail him at psurdock@mt.gov.

GLOSSARY OF TERMS

SED	Serious Emotional Disturbance
SOC	Children's System of Care Planning Committee
KMA	Kid Management Authority
SAA	Service Area Authority
DPHHS	Department of Public Health and Human Services

Appendix B

(2) "Serious emotional disturbance (SED)" means with respect to a youth between the ages of 6 and 17 years that the youth meets requirements of (2)(a) and either (2)(b) or (2)(c).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

- (i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);
- (ii) oppositional defiant disorder (313.81);
- (iii) autistic disorder (299.00);
- (iv) pervasive developmental disorder not otherwise specified (299.80);
- (v) asperger's disorder (299.80);
- (vi) separation anxiety disorder (309.21);
- (vii) reactive attachment disorder of infancy or early childhood (313.89);
- (viii) schizo affective disorder (295.70);
- (ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);
- (x) obsessive-compulsive disorder (300.3);
- (xi) dysthymic disorder (300.4);
- (xii) cyclothymic disorder (301.13);
- (xiii) generalized anxiety disorder (overanxious disorder) (300.02);
- (xiv) post-traumatic stress disorder (chronic) (309.81);
- (xv) dissociate identity disorder (300.14);
- (xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
- (xvii) anorexia nervosa (severe) (307.1);
- (xviii) bulimia nervosa (severe) (307.51);
- (xix) intermittent explosive disorder (312.34); and

(xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

b) As a result of the youth's diagnosis determined in (2)(a) and for a period of at least 6 months, or for a predictable period over 6 months the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;

(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;

(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;

(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or

(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous 6 months:

(i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in [20-7-401](#)(4), MCA with respect to which the youth is currently receiving special education services;

(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;

(iii) the juvenile correctional system, due to the diagnosis determined in (2)(a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or

(iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under 6 years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months and obviously predictable to continue for a period of at least 6 months, as manifested by one or more of the following:

(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;

(ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;

(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or

(vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers. (History: Sec. [53-2-201](#) and [53-6-113](#), MCA; [IMP](#), Sec. [53-6-101](#), MCA; [NEW](#), 1999 MAR p. 1301, Eff. 7/1/99; [TRANS](#), from SRS, 2000 MAR p. 481; [AMD](#), 2001 MAR p. 27, Eff. 1/12/01; [AMD](#), 2001 MAR p. 989, Eff. 6/8/01.)

Appendix 5:
Administrative Rules of Montana 2-3-103 MCA
Public Participation

Referenced:
Part B Development Plan
Question 2, Page 10

MONTANA CODE ANNOTATED 2005:
Administrative Rules Processes and Public Participation

2-4-103. Rules and statements to be made available to public. (1) Each agency shall:

(a) make available for public inspection all rules and all other written statements of policy or interpretations formulated, adopted, or used by the agency in the discharge of its functions;

(b) upon request of any person, provide a copy of any rule.

(2) Unless otherwise provided by statute, an agency may require the payment of the cost of providing such copies.

(3) No agency rule is valid or effective against any person or party whose rights have been substantially prejudiced by an agency's failure to comply with the public inspection requirement herein.

History: En. Sec. 3, Ch. 2, Ex. L. 1971; amd. Sec. 1, Ch. 240, L. 1974; amd. Sec. 3, Ch. 285, L. 1977; R.C.M. 1947, 82-4203(1)(c), (1)(d), (2); amd. Sec. 3, Ch. 243, L. 1979.

75-2-205. Public hearings on rules. No rule and no amendment or repeal thereof may take effect except after public hearing on due notice and after the advisory council has been given, at the time of publication, the proposed text to comment thereon. Such notice shall be given and any hearing conducted in accordance with the provisions of the Montana Administrative Procedure Act and rules made pursuant thereto.

History: En. Sec. 14, Ch. 313, L. 1967; amd. Sec. 9, Ch. 140, L. 1977; R.C.M. 1947, 69-3917(1); amd. Sec. 3, Ch. 560, L. 1979.

2-4-302. Notice, hearing, and submission of views. (1) Prior to the adoption, amendment, or repeal of any rule, the agency shall give written notice of its intended action. The notice must include a statement of either the terms or substance of the intended action or a description of the subjects and issues involved, the reasonable necessity for the intended action, and the time when, place where, and manner in which interested persons may present their views on the intended action. The reasonable necessity must be written in plain, easily understood language. If the agency proposes to adopt, increase, or decrease a monetary amount that a person shall pay or will receive, such as a fee, cost, or benefit, the notice must include an estimate, if known, of:

(a) the cumulative amount for all persons of the proposed increase, decrease, or new amount; and

(b) the number of persons affected.

(2) (a) The notice must be filed with the secretary of state for publication in the register, as provided in 2-4-312, and mailed within 3 days of publication to the sponsor of the legislative bill that enacted the section that is cited as implemented in the notice if the notice is the initial proposal to implement the section, to interested persons who have made timely requests to the agency to be informed of its rulemaking proceedings, and to the office of any professional, trade, or industrial society or organization or member of those entities who has filed a request with the appropriate administrative rule review committee when the request has been forwarded to the agency as provided in subsection (2)(b). Each agency shall create and maintain a list of interested persons and the subject or subjects in which each person on the list is interested. A person who submits a written comment or attends a hearing in regard to proposed agency action under this part must be informed of the list by the agency. An agency complies with this subsection if it includes in the notice an advisement explaining how persons may be placed on the list of

interested persons and if it complies with subsection (7).

(b) The appropriate administrative rule review committee shall forward a list of all organizations or persons who have submitted a request to be informed of agency actions to the agencies that the committee oversees that publish rulemaking notices in the register. The list must be amended by the agency upon request of any person requesting to be added to or deleted from the list.

(c) The notice required by subsections (1) and (2)(a) must be published and mailed at least 30 days in advance of the agency's intended action. In addition to publishing and mailing the notice under subsection (2)(a), the agency shall post the notice on a state electronic access system or other electronic communications system available to the public.

(d) The agency shall also, at the time that its personnel begin to work on the substantive content and the wording of the initial rule proposal to implement one or more statutes, notify the sponsor of the legislative bill that enacted the section.

(3) If a statute provides for a method of publication different from that provided in subsection (2), the affected agency shall comply with the statute in addition to the requirements contained in this section. However, the notice period may not be less than 30 days or more than 6 months.

(4) Prior to the adoption, amendment, or repeal of any rule, the agency shall afford interested persons at least 20 days' notice of a hearing and at least 28 days from the day of the original notice to submit data, views, or arguments, orally or in writing. If an amended or supplemental notice is filed, additional time may be allowed for oral or written submissions. In the case of substantive rules, the notice of proposed rulemaking must state that opportunity for oral hearing must be granted if requested by either 10% or 25, whichever is less, of the persons who will be directly affected by the proposed rule, by a governmental subdivision or agency, by the appropriate administrative rule review committee, or by an association having not less than 25 members who will be directly affected. If the proposed rulemaking involves matters of significant interest to the public, the agency shall schedule an oral hearing.

(5) An agency may continue a hearing date for cause. In the discretion of the agency, contested case procedures need not be followed in hearings held pursuant to this section. If a hearing is otherwise required by statute, nothing in this section alters that requirement.

(6) If an agency fails to publish a notice of adoption within the time required by 2-4-305(7) and the agency again proposes the same rule for adoption, amendment, or repeal, the proposal must be considered a new proposal for purposes of compliance with this chapter.

(7) At the commencement of a hearing on the intended action, the person designated by the agency to preside at the hearing shall:

(a) read aloud the "Notice of Function of Administrative Rule Review Committee" appearing in the register; and

(b) inform the persons at the hearing of the provisions of subsection (2)(a) and provide them an opportunity to place their names on the list.

(8) For purposes of notifying sponsors under subsections (2)(a) and (2)(d) who are no longer members of the legislature, a former legislator who wishes to receive notice may keep the former legislator's name, address, and telephone number on file with the secretary of state. An agency proposing rules shall consult the register when providing sponsor notice.

History: En. Sec. 4, Ch. 2, Ex. L. 1971; amd. Sec. 5, Ch. 410, L. 1975; amd. Sec. 1, Ch. 482, L. 1975; amd. Sec. 8, Ch. 285, L. 1977; R.C.M. 1947, 82-4204(part); amd. Sec. 4, Ch. 243, L. 1979; amd. Sec. 1, Ch. 381, L. 1981; amd. Sec. 1, Ch. 429, L. 1983; amd. Sec. 1, Ch. 152, L. 1997; amd. Sec. 1, Ch. 340, L. 1997; amd. Sec. 2, Ch. 489, L. 1997; amd. Sec. 3, Ch. 19, L. 1999; amd. Sec. 1, Ch. 41, L. 1999; amd. Sec. 2, Ch. 210, L. 2001.

Appendix 6:
Montana's Level of Care Assessment
Child Behavior Checklist (CBCL)

Referenced:
Part B Development Plan
Question 4, Page 12
Question 5, Page 14

Part D Evaluation
Question 1, Pages 22 and 23
Question 2, Page 24



Please print

CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER

☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP
OR RACE

TODAY'S DATE

Mo. ____ Day ____ Year ____

CHILD'S BIRTHDATE

Mo. ____ Day ____ Year ____

GRADE IN
SCHOOL ____NOT ATTENDING
SCHOOL ☐Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. **Be sure to answer all items.****PARENTS' USUAL TYPE OF WORK, even if not working now.**

(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S

TYPE OF WORK _____

MOTHER'S

TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent☐ Step Parent☐ Grandparent☐ Adoptive Parent☐ Foster Parent☐ Other (specify)**I. Please list the sports your child most likes**

to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

a. _____

b. _____

c. _____

Compared to others of the same age, about how much time does he/she spend in each?Less Than
Average

Average

More Than
AverageDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**Compared to others of the same age, how well does he/she do each one?**Below
Average

Average

Above
AverageDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**II. Please list your child's favorite hobbies, activities, and games, other than sports.**For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do **not** include listening to radio or TV.)None ☐

a. _____

b. _____

c. _____

Compared to others of the same age, about how much time does he/she spend in each?Less Than
Average

Average

More Than
AverageDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**Compared to others of the same age, how well does he/she do each one?**Below
Average

Average

Above
AverageDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**III. Please list any organizations, clubs, teams, or groups your child belongs to.**None ☐

a. _____

b. _____

c. _____

Compared to others of the same age, how active is he/she in each?Less
Active

Average

More
ActiveDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**IV. Please list any jobs or chores your child has.**

For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

a. _____

b. _____

c. _____

Compared to others of the same age, how well does he/she carry them out?Below
Average

Average

Above
AverageDon't
Know☐☐☐☐☐☐☐☐☐☐☐☐**Be sure you answered all items. Then see other side.**

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours?

(Do *not* include brothers & sisters)

☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has no brothers or sisters
b. Get along with other kids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Behave with his/her parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Play and work alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

VII. 1. Performance in academic subjects.

Does not attend school because _____

Check a box for each subject that child takes

Other academic subjects—for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.

	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ No ☐ Yes—kind of services, class, or school: _____

3. Has your child repeated any grades?

☐ No ☐ Yes—grades and reasons: _____

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe: _____

When did these problems start? _____

Have these problems ended? ☐ No ☐ Yes—when? _____

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe: _____

What concerns you most about your child? _____

Please describe the best things about your child. _____

Below is a list of items that describe children and youths. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2	1. Acts too young for his/her age	0 1 2	32. Feels he/she has to be perfect
0 1 2	2. Drinks alcohol without parents' approval (describe): _____	0 1 2	33. Feels or complains that no one loves him/her
0 1 2	3. Argues a lot	0 1 2	34. Feels others are out to get him/her
0 1 2	4. Fails to finish things he/she starts	0 1 2	35. Feels worthless or inferior
0 1 2	5. There is very little he/she enjoys	0 1 2	36. Gets hurt a lot, accident-prone
0 1 2	6. Bowel movements outside toilet	0 1 2	37. Gets in many fights
0 1 2	7. Bragging, boasting	0 1 2	38. Gets teased a lot
0 1 2	8. Can't concentrate, can't pay attention for long	0 1 2	39. Hangs around with others who get in trouble
0 1 2	9. Can't get his/her mind off certain thoughts; obsessions (describe): _____	0 1 2	40. Hears sound or voices that aren't there (describe): _____
0 1 2	10. Can't sit still, restless, or hyperactive	0 1 2	41. Impulsive or acts without thinking
0 1 2	11. Clings to adults or too dependent	0 1 2	42. Would rather be alone than with others
0 1 2	12. Complains of loneliness	0 1 2	43. Lying or cheating
0 1 2	13. Confused or seems to be in a fog	0 1 2	44. Bites fingernails
0 1 2	14. Cries a lot	0 1 2	45. Nervous, highstrung, or tense
0 1 2	15. Cruel to animals	0 1 2	46. Nervous movements or twitching (describe): _____
0 1 2	16. Cruelty, bullying, or meanness to others	0 1 2	47. Nightmares
0 1 2	17. Daydreams or gets lost in his/her thoughts	0 1 2	48. Not liked by other kids
0 1 2	18. Deliberately harms self or attempts suicide	0 1 2	49. Constipated, doesn't move bowels
0 1 2	19. Demands a lot of attention	0 1 2	50. Too fearful or anxious
0 1 2	20. Destroys his/her own things	0 1 2	51. Feels dizzy or lightheaded
0 1 2	21. Destroys things belonging to his/her family or others	0 1 2	52. Feels too guilty
0 1 2	22. Disobedient at home	0 1 2	53. Overeating
0 1 2	23. Disobedient at school	0 1 2	54. Overtired without good reason
0 1 2	24. Doesn't eat well	0 1 2	55. Overweight
0 1 2	25. Doesn't get along with other kids		56. Physical problems without known medical cause:
0 1 2	26. Doesn't seem to feel guilty after misbehaving	0 1 2	a. Aches or pains (not stomach or headaches)
0 1 2	27. Easily jealous	0 1 2	b. Headaches
0 1 2	28. Breaks rules at home, school, or elsewhere	0 1 2	c. Nausea, feels sick
0 1 2	29. Fears certain animals, situations, or places, other than school (describe): _____	0 1 2	d. Problems with eyes (not if corrected by glasses) (describe): _____
0 1 2	30. Fears going to school	0 1 2	e. Rashes or other skin problems
0 1 2	31. Fears he/she might think or do something bad	0 1 2	f. Stomachaches
		0 1 2	g. Vomiting, throwing up
		0 1 2	h. Other (describe): _____

Please print. Be sure to answer all items.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

- 0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____

0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____

0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____

0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____

0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____

0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____

0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____

- 0 1 2 84. Strange behavior (describe): _____

0 1 2 85. Strange ideas (describe): _____

0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____

0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____

0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (*don't* include alcohol or tobacco) (describe): _____

0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Appendix 7:
Yellowstone County KMA Letter of Support and MOU

Referenced:
Part B Development Plan
Question 4, Page 12

YELLOWSTONE COUNTY
Kids Management Authority (KMA)

Thirteenth Judicial District Youth Court Services
P.O. Box 35031
Billings, MT 59107

Ph. (406) 254-7990
Fax (406) 254-6041

September 29, 2006

RECEIVED

OCT 06 2006

HEALTH RESOURCES
DIVISION

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway RM- A 116
PO Box 202951
Helena, Montana 59620-2951

Dear Ms. Miles,

We are pleased to add our support to the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with Centers for Medicare & Medicaid Services, (CMS), entitled: Community- Based Alternatives to Psychiatric Residential Treatment Facilities. We understand this demonstration will provide the opportunity to:

1. Enhance family centered, community-based services that are delivered in a family environment.
2. Expand the array of services available to youth enrolled in the demonstration and that these services will enhance the opportunity to keep the family and child intact and avoid placement outside family.
3. Improve the quality of services provided to the youth and family.
4. Divert youth from out-of-home psychiatric residential services into culturally appropriate community-based family centered services.
5. Enhance parent and family roles in decision making pertaining to what services and the amount of service their child receives.
6. Enhance the capacity of our Medicaid program to evaluate the impact of mental health services provided to youth resulting in improved efficiency, reduction of long-term dependency on the Medicaid system, and reduce stigma suffered by individuals who suffer with mental illness.

We agree with the admission criteria for the demonstration as we concur that children with SED ages 6 to 16, who:

1. demonstrate complex health and mental needs
2. require institutional level of care
3. are at imminent risk of admission to psychiatric residential treatment facility (PRFT)
4. whose service and support needs cannot be met by just one agency, system, or service.
5. are capable of being cared for in the home and/or community if services are provided; and
6. have a viable and consistent living environment with parents/guardians/caregivers who are able and willing to participate in the demonstration grant, and support their child in the home and community.

We understand that a limited number of youth will be served by this grant initially, and support expansion to a larger target population as the demonstration progresses.

In summary we strongly encourage your approval of the DPHHS application for the demonstration grant. The focus of providing alternatives to residential treatment by wrapping individualized services around youth in their communities and in their homes is a primary objective of our organization. We believe this demonstration will provide us with the unique opportunity to effectively demonstrate the principles and values of the system of care of which we are a partner. Attached you will find our Memorandum of Understanding with member signatures in support of the DPHHS application.

Sincerely,



Melanie Redman
Project Director
Yellowstone County KMA

**Yellowstone County
KIDS MANAGEMENT AUTHORITY (KMA)**

MEMORANDUM OF UNDERSTANDING

Pursuant to the provisions of Section 52-2-211 MCA and Section 52-2-203 MCA, the undersigned parties, in mutual consideration of the premises, hereby establish the Yellowstone County Kids Management Authority, hereinafter referred to as the KMA, under the following terms and conditions.

SECTION I

PURPOSE

The KMA is a collaborative community effort to develop systems of care for children with a serious emotional disturbance (SED) and their families. The KMA shall operate on the basis of core values for community-based, child-centered, family-focused and culturally appropriate services. The essential features of this system include a unified plan of care, coordinated care management and service delivery, and integrated funding. The target population of the KMA includes, but is not limited to, children and adolescents with a serious emotional disturbance (SED) who require multi-agency intervention. Youth also identified as having significant family, legal, educational, behavioral, or emotional problems involving two or more community service agencies providing services in the area of mental health, education, juvenile justice, substance abuse, child protection or developmental disabilities, may be served by the KMA.

SECTION II

EFFECTIVE DATE AND TERM

This agreement shall become effective on the 7th day of Sept., 2005, and shall remain in force until revoked by a majority vote of those persons and agencies designated in paragraph 1 of Section III of this agreement that have signed this agreement and are current members. However any member designated in this section may withdraw from the KMA by giving sixty days notice in writing to the remaining team members as designated herein. This cooperative agreement shall be reviewed annually to include necessary revisions.

SECTION III

TEAM MEMBERSHIP

1. Pursuant to 52-2-203(1), MCA, state agencies shall enter into a cooperative agreement for the purpose of coordinating services to children with multi-agency service needs. The persons and entities or their designees who sign this agreement shall be the voting members of the KMA. The members shall set overall direction, develop and approve policies and procedures, control referrals, authorize funding commitments, and monitor the effectiveness of the KMA. Each person or entity designated below shall have one vote. An entity designee shall file a written authorization to act for and on behalf of the entity, which shall include a certification that the entity agrees to be bound by the terms and conditions of the agreement.

- a) Pursuant to 52-2-301(1), MCA, the legislature declares that it is the policy of this state: to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multi-agency service needs, to the extent that funds are available. The following public agency designees have decision-making authority and responsibility to determine which youth qualify for services through State general funds or other funding sources.
 1. Department of Public Health and Human Services, Region 3, Child and Family Services Division, Regional Administrator;
 2. Children's Mental Health Bureau, Region 3, Program Officer;
 3. Developmental Disability Services, Region 3, Regional Manager;
 4. 13th Judicial District Youth Court, Court Services Director;
 5. Department of Corrections, Juvenile Parole Officer;
 6. Billings Public Schools, Superintendent.
2. All KMA members that represent an entity may appoint in writing, such designee(s) as they shall deem appropriate.
3. The KMA may approve by majority vote any of the following persons or entities to sign a written agreement, participate in meetings, and serve either as voting members of or in an advisory capacity to the KMA:
 - a. Tribal Indian Youth representative;
 - b. Bureau of Indian Affairs designated representative;
 - c. Indian Health Services designated representative;
 - d. Agency mental health, child welfare and juvenile justice providers, physicians, psychiatrists, psychologists, nurses, social workers, licensed professional counselors, chemical dependency counselors and any other providers of mental or behavioral health care;
 - e. Entities operating private elementary and secondary schools;
 - f. Attorneys, guardians ad litem, CASA volunteers, law enforcement officers, or other court appointed legal advocates for children;
 - g. County Commissioners, Public Assistance representative, or Service Area Authority designee;
 - h. Parents, family members, advocates, or other stakeholders that have a legitimate interest in, and can contribute in a meaningful way to, the success of the KMA;
 - i. On a case-specific basis, any member of the youth's Individual Care Coordination Team or treatment team.
4. In addition, the voting members may from time to time request the assistance of other professionals and stakeholders from the community to participate in meetings on an ad hoc basis. These entities shall not be members and shall not have the right to vote.
5. The KMA shall, by a majority vote, have the authority to suspend any KMA member who shall fail to abide by the terms of the agreement.
6. The KMA shall review and authorize unified plans of care and budgets for those plans of care. For this purpose, they shall remain a separate, autonomous entity from a Provider Network. Only those entities specifically identified above as voting members of the KMA, with fiscal responsibility of state funds, may participate in the decision as to whether or not to approve a budget for that plan of care. It is intended that decisions by the KMA regarding the approval or disapproval of unified plans of care and the budgets for those plans of care be determined through a collaborative effort. However, in the case of an absence or dissent by one or more of the voting members of the KMA, nothing in this agreement shall be construed as allowing the remaining voting members to commit resources and make decisions on behalf of absent or dissenting members.

7. For the purpose of enhancing the collaborative decision making process on matters beyond authorizing funding for unified plans of care, the KMA may extend its membership to providers and other key stakeholders by a majority vote of the entire membership present

SECTION IV

ORGANIZATION

1. The Kids Management Authority (KMA) infrastructure is three-pronged.
 - a) The KMA Core Group is a multidisciplinary community team with a goal to achieve 51% parent participation. The role of the KMA is to provide leadership, sanction, and governance in the community and the design, implementation and support of a community based system of care. The KMA is responsible for reviewing care plans designed by the child's Individual Care Coordination Team and consider all possible funding options. It is the responsibility of the Children's System of Care Committee to empower their respective KMA counterparts to this end.
 - b) The role of the Individual Care Coordination Team (ICCT) is to develop, and implement unified care plans for specific youth and families.
 - c) The KMA Community Development Group seeks full community involvement to promote communication and collaboration between KMA members, consumers, providers and other key Stakeholders to establish a community-wide service delivery system.
2. The KMA shall conduct meetings and other business under Roberts Rules of Order or may enact their own operational rules.
3. The KMA may select a chairperson and a vice chairperson from its membership.
4. The KMA may appoint or hire a third party to act as the KMA Coordinator.
5. To the extent feasible, the KMA will draw from agency resources to commit in-kind support to ensure the effective functioning of the group. The KMA may request that a subcommittee of the group act as a steering committee to develop work in progress, organize agendas, and bring action items to the KMA for approval.
6. The KMA may, from time to time, form such ad hoc committees as shall be necessary to carry out the functions of the KMA. At the discretion of the KMA, these committees may involve any entity that serves in an advisory capacity to the KMA.
7. The KMA shall meet on a regularly scheduled basis and at additional time as may be required. All meetings of the KMA shall be open to the public, except as provided under the open meeting law, or where specific cases or individuals are discussed.
8. The KMA shall have the following responsibilities:
 - a. provide local governance and oversight;
 - b. identify a KMA Coordinator whose responsibilities include; scheduling and coordination of referrals, maintaining centralized records, data collection, and reporting;
 - c. review cases of the prioritized target population and, when appropriate, referring the case to an Individual Care Coordination Team for the development of unified plans of care;

- d. share financial information and coordinate funding streams in accordance with state and federal rules, laws, or policies developed by the SOC to pay for services approved in the unified plans of care;
 - e. exercise funding decisions and approve budgets for unified plans of care;
 - f. in partnership with the providers, assess community needs and promote development of service array and community capacity;
 - g. provide on-going training and human resource development opportunities to ensure the availability of a cadre of trained individual care team leaders in the community;
 - h. respond to requests from DPHHS and the SOC for information such as finance reports, outcome measures, service delivery data, etc.
9. The KMA is to perform such other duties as are necessary to carry out the purposes of this agreement.
10. The KMA may expand on the functions of the county interdisciplinary child information team, youth placement committee and the child protective team, as authorized by 52-2-211, by maintaining representation on the KMA of members of those teams. This will seek to reduce duplication of services in addition to enhancing the quality of decision-making and efficiency of services by consolidating the information established by the various child-serving agencies.

SECTION V

INFORMATION MANAGEMENT

- 1) Definitions:
- a) information management as used in this agreement means the process whereby information concerning a youth who is within the definition contained in Section 52-2-211 MCA, his/her siblings and family, is validated, disseminated, and the legal requirements for confidentiality are maintained by any person or agency who has signed this agreement;
 - a) validated information means information that is delineated in 52-2-211 and is current, accurate, and relevant;
 - b) disseminated means the procedural rules and the release of otherwise confidential information to persons and agencies that have signed this agreement and the limitation on further dissemination as required under Section 52-2-204 (4).
- 2) The persons and agencies that have signed this agreement hereby agree to:
- a) develop internal policies to validate information in youth files and to provide for periodic reviews to ensure compliance;
 - b) designate a youth information liaison person(s) who will be responsible for releasing youth information pursuant to the operational procedures adopted by the KMA;
 - c) adopt and enforce internal policies, which will ensure that information regarding a child that a KMA member supplies to other KMA members or that is disseminated to a KMA member under 41-3-205, 41-5-602, or 41-5-603 is not disseminated beyond the KMA.
- 3) Information exchange between KMA members, to include auxiliary or nonvoting members:
- a) Pursuant to 41-5-215(2), MCA;
 - i) youth court records may be disclosed to inter-disciplinary team members. Also, pursuant to 41-3-205(3) (w), MCA, DPHHS records of a youth may be disclosed to interdisciplinary team members. In addition, pursuant to 52-2-211(7), MCA, school districts may release education records to the interdisciplinary team upon written certification to the school district releasing the records that the education records and other records so released will not be disclosed to any other party without prior written consent of the parent/guardian.

- ii) These provisions notwithstanding, all information acquired by the KMA pursuant to this agreement shall constitute confidential information. Accordingly, information regarding any child or family served by this agreement shall not be shared, distributed or otherwise released to any person or entity that is not a KMA member or otherwise entitled to such confidential information under law.
- b) All written dissemination shall be marked individually or fastened together with a cover sheet, with the following warning clearly visible: "NOT FOR DISSEMINATION BEYOND THE MEMBERS OF THE YELLOWSTONE COUNTY KMA".
- c) The KMA may establish a file for a child who is being served by the KMA;
 - i) Such files shall be maintained in a manner as to be secure from unauthorized access;
 - ii) Such files shall be maintained or purged as determined by the KMA members providing services;
 - iii) The files may be hard copy or computerized or a combination of both.

SECTION VI

RELATIONSHIP TO OTHER LEGAL DUTIES

1. This agreement shall be construed in a manner to be consistent with the statutory and administrative duties of the KMA members.
2. The informal request for information sharing from other KMA members or a formal request to the coordinator for information or for staffing of a case does not relieve the party requesting such information from the statutory duty to report abuse/neglect cases to the Department of Public Health and Human Services as required under Section 41-3-201.

SECTION VII

MODIFICATION

This agreement may be modified by a majority vote of the entities designated in section III, paragraph 1 who have signed the agreement and are active members at the time of the vote.


SECTION VIII

ACCEPTANCE OF TERMS OF AGREEMENT

By signing this agreement all signatories individually agree to be bound by the terms thereof, and those signing for an agency, department or association hereby certify that they have the authority to bind their agency, department, or organization to the terms and conditions of said agreement.

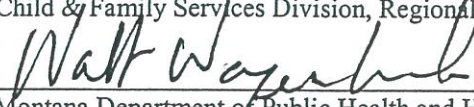
SECTION IX

SECTION III, PARAGRAPH 1


Montana Department of Public Health and Human Services
Child & Family Services Division, Regional Administrator

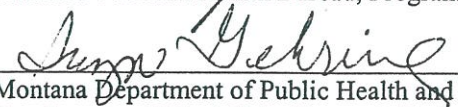
Date

9-6-05


Montana Department of Public Health and Human Services
Children's Mental Health Bureau, Program Officer

Date

9.2.05


Montana Department of Public Health and Human Services
Developmental Disabilities Program, Regional Manager

Date

9-6-05


13th Judicial District Youth Court, Court Services Director

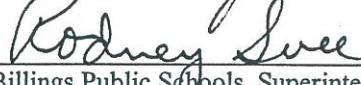
Date

9/2/05


Department of Corrections, Juvenile Parole Officer

Date

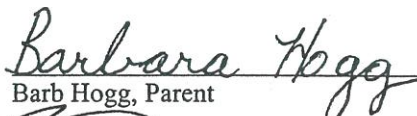
9/7/05


Billings Public Schools, Superintendent

Date

9-7-05

SECTION III, PARAGRAPH 3


Barb Hogg, Parent


Date

8-30-05


Ron Walters, Parent


Date

8.30.05


Libby Houghton, Parent

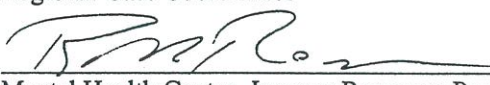
Date

9-6-05


First Health Services of Montana
Regional Care Coordinator

Date

9.6.05


Mental Health Center, Journey Recovery Program
Executive Director

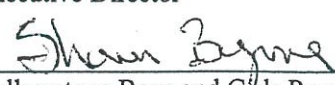
Date

9.6.05


Parents Let's Unite For Kids (PLUK)
Executive Director

Date

9-2-05


Yellowstone Boys and Girls Ranch
Director of Community Based Services

Date

9-2-05

Appendix 8:
ARM 37.85.401 – 402
Provider Participation

Referenced:
Part B Development Plan
Question 7, Page 15

Administrative Rules of Montana: Provider Participation, Enrollment and Agreements

[37.85.401 PROVIDER PARTICIPATION](#) (1) As a condition of participation in the Montana Medicaid program all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Medicaid Program and all applicable Montana statutes and rules governing licensure and certification. (History: [53-6-113](#), MCA; [IMP](#), [53-2-201](#), [53-6-101](#), [53-6-111](#), [53-6-113](#), [53-6-141](#), MCA; [NEW](#), 1980 MAR p. 1491, Eff. 5/16/80; [AMD](#), 1997 MAR p. 474, Eff. 3/11/97; [TRANS](#), from SRS, 2000 MAR p. 479.)

[37.85.402 PROVIDER ENROLLMENT AND AGREEMENTS](#)

(1) Providers must enroll in the Montana Medicaid program for each category of services to be provided. As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require the provider to:

- (a) complete and submit an enrollment application or form;
 - (b) complete and submit agreements or other forms applicable to the provider's category of service;
 - (c) provide information and documentation regarding ownership and control of the provider entity and regarding the provider's ownership interest or control rights in other providers that bill Medicaid;
 - (d) provide information and documentation regarding:
 - (i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the Medicare program, any state Medicaid program or other federal program against the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and
 - (ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person's or entity's involvement in Medicare, Medicaid, or the Title XX Services program; and
 - (e) submit documentation and information demonstrating compliance with participation requirements applicable to the provider's category of service.
- (2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.
- (a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new program category. The change

in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) Except as provided in (2)(a), an approved enrollment is effective on the later of:

(a) one year prior to the date the completed enrollment application is received by the department's fiscal agent; or

(b) the date as of which all required licenses and certifications are effective.

- Appendix 9:**
Letters of Commitment and Support
- Governor's Disability Advisory Council
 - NAMI Montana
 - Department of Corrections Youth Services
 - Montana Youth Courts
 - Office of Public Instruction
 - Parents Let's Unite for Kids (PLUK)

Referenced:
Part B Development Plan
Question 11, Page 18

GOVERNOR'S DISABILITY ADVISORY COUNCIL



BRIAN SCHWEITZER
GOVERNOR

BRYHER HERAK
CHAIR

STATE OF MONTANA

PO Box 4210
HELENA, MT 59604-4210

October 12, 2006

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway RM- A 116
PO Box 202951
Helena, Montana 59620-2951

Dear Director Miles:

The Governor's Council on Disabilities offers this letter of support for the Department's Health Resources Division's, Children's Mental Health Bureau, application for a demonstration project with Centers for Medicare & Medicaid Services, (CMS), entitled: Community- Based Alternatives to Psychiatric Residential Treatment Facilities. We understand this demonstration will provide the opportunity to:

1. Enhance family centered, community-based services that are delivered in a family environment.
2. Expand the array of services available to youth enrolled in the demonstration and that these services will enhance the opportunity to keep the family and child intact and avoid placement outside family.
3. Improve the quality of services provided to the youth and family.
4. Divert youth from out-of-home psychiatric residential services into culturally appropriate community-based family centered services.
5. Enhance parent and family roles in decision making pertaining to what services and the amount of service their child receives.
6. Enhance the capacity of our Medicaid program to evaluate the impact of mental health services provided to youth resulting in improved efficiency, reduction of long-term dependency on the Medicaid system, and reduce stigma suffered by individuals who suffer with mental illness.

The Governor's Disabilities Advisory Council is directed by Executive Order to advise the Governor's Office, and other Executive branch entities, on issues affecting the implementation of the Americans with Disabilities Act (ADA) and Montana's Olmstead (most integrated setting) plans. At least sixty percent (60%) of the members must be persons with disabilities – providing a clear understanding of the issues noted above. The Council wholeheartedly supports community-based opportunities to insure that children are safe and provided comprehensive services that can help keep families intact – we believe this demonstration grant will support and enhance current efforts by the Department's Health Resources Division.

The Governor's Disabilities Advisory Council encourages your approval of the Community-Based Alternatives to Psychiatric Residential Treatment Facilities demonstration project.

Respectfully,

A handwritten signature in dark ink, appearing to read "Bryher Herak", with a stylized flourish at the end.

Bryher Herak, Chair
Governor's Disabilities Advisory Council



NAMI
montana

PO Box 1021
Helena MT 59624
(406) 443-7871
namimt@ixi.net

October 5, 2006

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway, Room A 116
P. O. Box 202951
Helena, Montana 59620-2951

Dear Ms. Miles,

NAMI-Montana is pleased to add our support to the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with the Centers for Medicare & Medicaid Services (CMS) entitled: Community-Based Alternatives to Psychiatric Residential Treatment Facilities.

NAMI-Montana looks forward to working with the Children's Mental Health Bureau to develop a program of parent and family education for families whose children suffer from Severe Emotional Disturbances or Early Age Onset Mental Illness. Education, advocacy and support for families is what NAMI-Montana does best. Over the last nine years over 1000 family members have taken our Family-to-Family Education Program in the state of Montana. We have also taught the Peer-to-Peer Education Program to adult consumers living with severe mental illness and have taught the NAMI Provider Education Course to mental health professionals in seven mental health facilities.

We are acutely aware of the fact that education and support for families can improve treatment outcomes and improve the family environment.

NAMI-Montana is an organization which advocates for children with mental illnesses and their families. We feel providing alternatives to residential treatment by wrapping individualized services around youth in their communities and in their homes is a vital part of successful treatment. We believe this demonstration will provide mentally ill children and their families needed services to maintain children with their families.

Sincerely,

Dr. Gary L. Mihelish, President
NAMI-Montana

YOUTH SERVICES
DEPARTMENT OF CORRECTIONS

STEVE GIBSON, DIVISION ADMINISTRATOR



STATE OF MONTANA

1539 11th Avenue
PO Box 201301
Helena, MT 59620-1301
TELEPHONE: (406) 444-0851
FAX: (406) 444-0522

October 3, 2006

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway Rm – A 116
PO Box 202951
Helena MT 59620-2951

Dear Ms. Miles,

We are pleased to add our support to the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with Centers for Medicare & Medicaid Services, (CMS), entitled: Community-Based Alternatives to Psychiatric Residential Treatment Facilities. We understand this demonstration will provide the opportunity to:

1. Enhance family centered, community-based services that are delivered in a family environment.
2. Expand the array of services available to youth enrolled in the demonstration and that these services will enhance the opportunity to keep the family and child intact and avoid placement outside family.
3. Improve the quality of services provided to the youth and family.
4. Divert youth from out-of-home psychiatric residential services into culturally appropriate community-based family centered services.
5. Enhance parent and family roles in decision making pertaining to what services and the amount of service their child receives.
6. Enhance the capacity of our Medicaid program to evaluate the impact of mental health services provided to youth resulting in improved efficiency, reduction of long-term dependency on the Medicaid system, and reduce stigma suffered by individuals who suffer with mental illness.

Joan Miles, Director
October 3, 2006
Page Two

We agree with the admission criteria for the demonstration as we concur that children with SED ages 6 to 16, who:

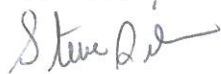
1. demonstrate complex health and mental needs;
2. require institutional level of care;
3. are at imminent risk of admission to psychiatric residential treatment facility (PRFT);
4. whose service and support needs cannot be met by just one agency, system, or service;
5. are capable of being cared for in the home and/or community if services are provided; and,
6. have a viable and consistent living environment with parents/guardians/caregivers who are able and willing to participate in the demonstration grant, and support their child in the home and community.

We understand that a limited number of youth will be served by this grant initially, and support expansion to a larger target population as the demonstration progresses.

The Department of Corrections provides services to some youth from age 10 through 17 with SED. We feel that providing alternatives to residential treatment by using individualized services for families and youth in their communities while they remain at home will enhance the ability of the Department of Corrections to coordinate with other stakeholders in the community to avoid inappropriate or unnecessary out of home placement and be able to maintain youth in their own communities.

In summary we strongly encourage your approval of the DPHHS application for the demonstration grant.

Sincerely,



STEVE GIBSON
Director
Youth Services

SG/jeb

I:\Juvenile_Placement\Steve Gibson\Joan Miles demonstration grant.doc

The Supreme Court of Montana
Office of the Court Administrator

Lois Menzies
Court Administrator



301 South Park
P.O. Box 203005
Helena, Montana 59620-3002
Telephone (406) 841-2950
FAX (406) 841-2955

October 4, 2006

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway RM- A 116
PO Box 202951
Helena, Montana 59620-2951

Dear Ms. Miles,

We are pleased to support the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with Centers for Medicare & Medicaid Services, (CMS), entitled: Community-Based Alternatives to Psychiatric Residential Treatment Facilities. It is our understanding that new services to qualified families are being proposed and that when combined with the current services offered, it could ultimately help us keep SED children out of residential treatment.

Quality community-based services are essential in order to keep families together and avoid placements outside the home. It is realized that not all youth can be treated within their own homes and communities, but agencies working together can greatly reduce the need for residential treatment, as long as we have the appropriate wrap-around services in place. Providing the needed education and services to families will give them hope and help produce a positive environment for the youth to prosper.

The Court Services Division feels strongly about strengthening the family unit through education and providing them with the support needed to keep their families together. We encourage the approval of the DPHHS application for the demonstration grant and wholeheartedly support your efforts to do what is right for individuals suffering from mental illness.

Sincerely,

A handwritten signature in blue ink that reads "Robert J. Peake".

Robert J. Peake, Bureau Chief
Youth and District Court Services
Supreme Court Administration



OFFICE OF PUBLIC INSTRUCTION

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Lynn
Linda McCulloch
Superintendent

October 6, 2006

Joan Miles, Director
Department of Public Health and Human Services
1400 Broadway RM- A 116
PO Box 202951
Helena, Montana 59620-2951

Dear Joan,

We are pleased to add our support to the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with Centers for Medicare and Medicaid Services, (CMS), titled: Community-Based Alternatives to Psychiatric Residential Treatment Facilities.

Schools often find themselves "on the frontline" in meeting the needs of children with serious emotional disturbance. When schools and community-based providers collaborate on services to children with emotional disturbance, the effectiveness of all programs is dramatically enhanced. This grant provides significantly expanded opportunities to coordinate programs. As a result, schools, community providers, and most importantly, the children will benefit.

Schools will benefit from this community-based support in a variety of ways. For example, the availability of on-site crisis intervention will support schools in the event of a crisis. Services to help de-escalate and stabilize the child will directly contribute to maintaining the child in the school and support schools in their effort to meet the educational and behavioral needs of the child.

Other provisions in the grant include medication management and education and support of parents. Proper medication management can have a direct impact on schools by decreasing behavior problems and helping the child focus on instruction. High-quality education and support of parents are essential for families and schools to improve coordination of behavior management plans and other forms of intervention. Additionally, the grant will support parents' understanding and ability to cope with the dynamics of their child's illness. We anticipate that when parents are provided information that assists them in better understanding their child's illness, communication between the family and school will be enhanced.

We are especially pleased that the grant focuses on enhancing family-centered, community-based services that are delivered in a family environment. Partnering in the community and

"It is the mission of the Office of Public Instruction to improve teaching and learning through communication, collaboration, advocacy, and accountability to those we serve."

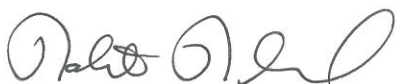
strengthening the involvement of parents compliments special education's approach to serving students with disabilities.

The public school system provides services to children with SED on a daily basis, and we feel that providing alternatives to residential treatment by wrapping individualized services around youth in their communities and in their homes will enhance the ability of the schools to provide the most appropriate educational program that will meet each child's needs. Keeping children in their own communities provides them with the consistency and stability that promotes learning.

Improving outcomes for children with disabilities is a top priority for public education. This demonstration project provides the types of support to families and communities that will provide viable alternatives to residential placement. Perhaps even more importantly, it is our hope that a well-coordinated community-based system of supports will help our schools improve educational and lifetime outcomes for children with serious emotional disturbance.

In summary, we strongly encourage your approval of the DPHHS application for the demonstration grant.

Sincerely,

A handwritten signature in dark ink, appearing to read "Bob Runkel", written in a cursive style.

Bob Runkel, Administrator
Division of Special Education



Parents, Let's Unite for Kids

DPHHS
Joan Miles
PO Box 202951
Helena MT 59620

10/16/2006

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- Billings MT 59101
- Ph 406.255.0540
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Dear Ms. Miles,

We are pleased to add our support to the Department's Health Resources Division's Children's Mental Health Bureau application for a demonstration project with Centers for Medicare & Medicaid Services, (CMS), entitled: Community- Based Alternatives to Psychiatric Residential Treatment Facilities. We understand this demonstration will provide the opportunity to:

1. Enhance family centered, community-based services that are delivered in a family environment.
2. Expand the array of services available to youth enrolled in the demonstration and that these services will enhance the opportunity to keep the family and child intact and avoid placement outside family.
3. Improve the quality of services provided to the youth and family.
4. Divert youth from out-of-home psychiatric residential services into culturally appropriate community-based family centered services.
5. Enhance parent and family roles in decision making pertaining to what services and the amount of service their child receives.
6. Enhance the capacity of our Medicaid program to evaluate the impact of mental health services provided to youth resulting in improved efficiency, reduction of long-term dependency on the Medicaid system, and reduce stigma suffered by individuals who suffer with mental illness.

We agree with the admission criteria for the demonstration as we concur that children with SED ages 6 to 16, who:

1. demonstrate complex health and mental needs
2. require institutional level of care
3. are at imminent risk of admission to psychiatric residential treatment facility (PRFT)
4. whose service and support needs cannot be met by just one agency, system, or service.
5. are capable of being cared for in the home and/or community if services are provided; and

6. have a viable and consistent living environment with parents/guardians/caregivers who are able and willing to participate in the demonstration grant, and support their child in the home and community.

We understand that a limited number of youth will be served by this grant initially, and support expansion to a larger target population as the demonstration progresses.

As an organization that advocates for children with mental illness and families who care for their mentally ill children, we feel that providing alternatives to residential treatment by wrapping individualized services around youth in their communities and in their homes is a vital part of our agency vision. We believe this demonstration will provide mentally ill children and their families needed services to maintain children with their families.

In summary we strongly encourage your approval of the DPHHS application for the demonstration grant.

Sincerely,

A handwritten signature in black ink, appearing to read "Roger", followed by a long, sweeping horizontal line that extends to the right.

Roger Holt,
PLUK Co-Executive Director

**Appendix 10:
Statement of Assurance**

**Referenced:
Part B Development Plan
Question 12, Page 18**

STATEMENT OF ASSURANCE

Montana will assure the necessary safeguards to protect the health and welfare of youth receiving home and community-based care under this demonstration. In accordance with 42 CFR §441.302, Montana makes the following assurances.

A. Health & Welfare: Montana will ensure that necessary safeguards will be taken to protect the health and welfare of persons receiving services under this demonstration. These safeguards include:

1. Adequate standards for all types of providers who provide services under this demonstration;
2. Any State licensure or certification requirements for services or for individuals furnishing services provided under the demonstration will be met. The State assures that these requirements are met on the date that the services are furnished; and,
3. All facilities subject to §1616(e) of the Act where home and community based demonstration project services are provided comply with the applicable State standards for board and care facilities.

B. Financial Accountability: Montana assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the demonstration project.

C. Evaluation of Need: Montana will provide for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this demonstration project, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this demonstration project.

D. Choice of Alternatives: Montana assures that when an individual is determined likely to require the level of care specified for this demonstration project *and* is in the specified target group, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives; and,
2. Given the choice of either institutional or home and community-based demonstration services.

E. Average Per Capita Expenditures: Montana assures that, for any year that the demonstration is in effect, the average per capita expenditures will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.

F. Actual Total Expenditures: Montana assures that the actual total expenditures for home and community-based and other Medicaid services and its claim for federal financial participation in expenditures for the services provided to individuals under the demonstration will not, in any year of the demonstration project period, exceed 100 percent of the amount that would be incurred in the absence of the demonstration project by Montana's Medicaid program for these individuals in the institutional setting(s) specified.

G. Institutionalization Absent: Montana assures that, absent the demonstration project, individuals served would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this project.

H. Reporting: Montana assures that it annually will provide CMS with information concerning the impact of the demonstration project on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of project participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. Montana assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the demonstration project will be: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Children and Youth with Severe Emotional Disturbance. Montana assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinical services provided as home and community-based services to children and youth with Severe Emotional Disturbance if these individuals, in the absence of the demonstration project, would be placed in a PRTC and are aged 6 to 16;.

Appendix 11:
Assessment Tools
– BERS
– YSS-Y and YSS-F
– GAIN

Referenced:
Part D Evaluation
Question 1, Page 22

BERS-2

Behavioral and Emotional Rating Scale—Second Edition

Parent Rating Scale

Section 1. Identifying Information

Name _____ Female ☐ Male ☐ Grade _____
Date Rated _____ School _____
Date of Birth _____ Rater's Name _____
Age _____ Rater's Relationship to Individual _____

Section 2. Score Summary

	Raw Score	%ile Rank	Scaled Score
I. Interpersonal Strength (IS)	_____	_____	<input type="text"/>
II. Family Involvement (FI)	_____	_____	<input type="text"/>
III. Intrapersonal Strength (IaS)	_____	_____	<input type="text"/>
IV. School Functioning (SF)	_____	_____	<input type="text"/>
V. Affective Strength (AS)	_____	_____	<input type="text"/>
Sum of Scaled Scores			_____
BERS-2 Strength Index		_____	<input type="text"/>
Supplemental			
VI. Career Strength (CS)	_____	_____	<input type="text"/>

Section 3. Interpretation and Recommendations

Section 4. Other Pertinent Information

Who referred the student? _____
What was the reason for the referral? _____
Parental permission obtained on (date) _____
BERS-2 results included in staffing or planning conference? ☐ Yes ☐ No

Section 5. Parent Rating Items

Directions: This scale contains a series of statements that are used to rate your child's behaviors and emotions in a positive way. Read each statement and mark the number that corresponds to the rating that best describes your child's status over the past 3 months. Rate each statement to the best of your knowledge of your child. Rate all 57 items by the following criteria:

3 = If the statement is very much like your child

2 = If the statement is like your child

1 = If the statement is not much like your child

0 = If the statement is not at all like your child

Statement		IS	FI	IaS	SF	AS
1. Demonstrates a sense of belonging to family	3 2 1 0		_____			
2. Trusts a significant person with his or her life	3 2 1 0		_____			
3. Accepts a hug	3 2 1 0					_____
4. Participates in community activities	3 2 1 0		_____			
5. Is self-confident	3 2 1 0			_____		
6. Acknowledges painful feelings	3 2 1 0					_____
7. Maintains positive family relationships	3 2 1 0		_____			
8. Demonstrates a sense of humor	3 2 1 0			_____		
9. Asks for help	3 2 1 0					_____
10. Uses anger management skills	3 2 1 0	_____				
11. Communicates with parents about behavior at home	3 2 1 0		_____			
12. Expresses remorse for behavior that hurts or upsets others	3 2 1 0	_____				
13. Shows concern for the feelings of others	3 2 1 0					_____
14. Completes a task on first request	3 2 1 0				_____	
15. Interacts positively with parents	3 2 1 0		_____			
16. Reacts to disappointments in a calm manner	3 2 1 0	_____				
17. Considers consequences of own behavior	3 2 1 0	_____				
18. Accepts criticism	3 2 1 0	_____				
19. Participates in religious activities	3 2 1 0		_____			
20. Demonstrates age-appropriate hygiene skills	3 2 1 0			_____		
21. Requests support from peers and friends	3 2 1 0			_____		
22. Enjoys a hobby	3 2 1 0			_____		
23. Discusses problems with others	3 2 1 0					_____
24. Completes school tasks on time	3 2 1 0				_____	
25. Accepts the closeness and intimacy of others	3 2 1 0					_____
26. Identifies own feelings	3 2 1 0			_____		
27. Identifies personal strengths	3 2 1 0			_____		
28. Accepts responsibility for own actions	3 2 1 0	_____				
29. Interacts positively with siblings	3 2 1 0		_____			
30. Loses a game gracefully	3 2 1 0	_____				
Column Subtotals						

3 = If the statement is very much like your child
 2 = If the statement is like your child
 1 = If the statement is not much like your child
 0 = If the statement is not at all like your child

Statement		IS	FI	IaS	SF	AS
31. Completes homework regularly	3 2 1 0				_____	
32. Is popular with peers	3 2 1 0			_____		
33. Listens to others	3 2 1 0	_____				
34. Expresses affection for others	3 2 1 0					_____
35. Admits mistakes	3 2 1 0	_____				
36. Participates in family activities	3 2 1 0		_____			
37. Accepts "no" for an answer	3 2 1 0	_____				
38. Smiles often	3 2 1 0			_____		
39. Pays attention in class	3 2 1 0				_____	
40. Computes math problems at or above grade level	3 2 1 0				_____	
41. Reads at or above grade level	3 2 1 0				_____	
42. Is enthusiastic about life	3 2 1 0			_____		
43. Respects the rights of others	3 2 1 0	_____				
44. Shares with others	3 2 1 0	_____				
45. Complies with rules at home	3 2 1 0		_____			
46. Apologizes to others when wrong	3 2 1 0	_____				
47. Studies for tests	3 2 1 0				_____	
48. Talks about the positive aspects of life	3 2 1 0			_____		
49. Is kind toward others	3 2 1 0	_____				
50. Uses appropriate language	3 2 1 0	_____				
51. Attends school regularly	3 2 1 0				_____	
52. Uses note-taking and listening skills in school	3 2 1 0				_____	
Column Subtotals						
Previous Page Column Subtotals						
Total Raw Score for PRS						

Supplemental Career Strength (CS) Subscale

53. Can name one career or life goal	3 2 1 0	_____
54. Is optimistic about future	3 2 1 0	_____
55. Actively plans for his or her future	3 2 1 0	_____
56. Has a specific vocational skill	3 2 1 0	_____
57. Has identified career goals	3 2 1 0	_____

Totals

Section 6. Key Questions

1. My child's favorite hobbies or activities are _____

2. My child's favorite sport(s) is (are) _____

3. My child's favorite school subject(s) is (are) _____

4. My child's best friend(s) is (are) _____

5. My child's favorite teacher(s) is (are) _____

6. In the community, my child has worked or volunteered at _____

7. The most important people in my child's life are _____

8. The best thing about my child is _____

This study is authorized by Section 565 of the Public Health Service Act. Public reporting burden for this collection of information is estimated to average 5 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0257); OAS; 1 Choke Cherry Road, Rockville, MD 20857.

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YOUTH SERVICES SURVEY

Abbreviated Version (YSS)

YSSDATE (Today's Date)

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

CHILDDID (Macro-assigned ID)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

TIMEFRAM (Assessment Period)

- 2 = 6 months
- 3 = 12 months
- 4 = 18 months
- 5 = 24 months
- 6 = 30 months
- 7 = 36 months

YSSINTV (Who administered interview)

- 2 = Data collector

YSSMETH (Method of administering interview)

- 1 = In person, hard copy
- 2 = Telephone, hard copy
- 3 = In person, computer assisted
- 4 = Telephone, computer assisted

YSSLANG (Language version of interview)

- 1 = English
- 2 = Spanish
- 3 = Other

--	--	--	--	--	--	--	--

Please think about all the services you and your family received over the past 6 months. These services may include treatment received from a therapist or clinician such as individual therapy, or support such as case management, or transportation. These services may also include help you and your family received through your school, a child welfare agency, the police, and the courts. All of these services are part of the service system in your community that works with children and families.

Have you or your family received any services like these in the past 6 months?

1 = No [END OF QUESTIONNAIRE]

2 = Yes [IF YES, continue to read instructions and administer questionnaire]

We are interested in knowing what you think about the services you and your family received during the past 6 months.

Your opinions are important so please be honest and tell us what you think. We want to know how you felt, good *or* bad! Remember that what you say will be kept confidential. People that provide services to you and your family will never find out what you have told us.

I will read you several statements. For each of the statements, please tell me the extent to which you disagree or agree that the statement describes your experience.

[CARD #1]

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1.	Overall, I am satisfied with the services I received.	1	2	3	4	5
2.	I helped to choose my services.	1	2	3	4	5
3.	I helped to choose my treatment goals.	1	2	3	4	5
4.	The people helping me stuck with me no matter what.	1	2	3	4	5
5.	I felt I had someone to talk to when I was troubled.	1	2	3	4	5
6.	I participated in my own treatment.	1	2	3	4	5
7.	I received services that were right for me.	1	2	3	4	5
8.	The location of services was convenient.	1	2	3	4	5
9.	Services were available at times that were convenient for me.	1	2	3	4	5

CHILD ID:

--	--	--	--	--	--	--	--

Youth Services Survey, Abbreviated Version (YSS)

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
10.	I got the help I wanted.	1	2	3	4	5
11.	I got as much help as I needed.	1	2	3	4	5
12.	Staff treated me with respect.	1	2	3	4	5
13.	Staff respected my family's religious and spiritual beliefs.	1	2	3	4	5
14.	Staff spoke with me in a way that I understood.	1	2	3	4	5
15.	Staff were sensitive to my cultural and ethnic background.	1	2	3	4	5
As a result of the services I received:						
16.	I am better at handling daily life.	1	2	3	4	5
17.	I get along better with family members.	1	2	3	4	5
18.	I get along better with friends and other people.	1	2	3	4	5
19.	I am doing better in school or work.	1	2	3	4	5
20.	I am better able to cope when things go wrong.	1	2	3	4	5
21.	I am satisfied with my family life right now.	1	2	3	4	5

22. **What has been the most helpful thing about the services you received over the last 6 months?**

* Developed by Molly Brunk et al., 1999.

YSS

CARD 1

1 = Strongly disagree

2 = Disagree

3 = Undecided

4 = Agree

5 = Strongly agree

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YOUTH SERVICES SURVEY FOR FAMILIES

Abbreviated Version (YSS-F): Caregiver

YSSFDATE (Today's Date)

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

CHILDID (Macro-assigned ID)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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TIMEFRAM (Assessment Period)

- 2 = 6 months
- 3 = 12 months
- 4 = 18 months
- 5 = 24 months
- 6 = 30 months
- 7 = 36 months

YSSFRESP (Respondent for interview)

- 1 = Caregiver (child's caregiver in a family, household environment)

YSSFINTV (Who administered interview)

- 2 = Data collector

YSSFMETH (Method of administering interview)

- 1 = In person, hard copy
- 2 = Telephone, hard copy
- 3 = In person, computer assisted
- 4 = Telephone, computer assisted

YSSFLANG (Language version of interview)

- 1 = English
- 2 = Spanish
- 3 = Other

--	--	--	--	--	--	--	--

Please think about all the services (*child's name*) and your family may have received over the past 6 months. These services may include treatment received from a therapist or clinician such as individual therapy, or support such as case management, or transportation. These services may also include help (*child's name*) and your family may have received through your school, a child welfare agency, the police, and the courts. All of these services are part of the service system in your community that works with children and families.

Have (*child's name*) or your family received any services like these in the past 6 months?

1 = No [END OF QUESTIONNAIRE]

2 = Yes [IF YES, continue to read instructions and administer questionnaire]

We are interested in knowing what you think about the services your child and family have received during the past 6 months.

Your opinions are important so please be honest and tell us what you think. We want to know how you felt, good *or* bad! Remember that what you say will be kept confidential. People that provide services to (*child's name*) and your family will never find out what you have told us.

I will read you several statements. For each of the statements, please tell me the extent to which you disagree or agree that the statement describes your experience.

[CARD #1]

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1.	Overall, I am satisfied with the services my child received.	1	2	3	4	5
2.	I helped to choose my child's services.	1	2	3	4	5
3.	I helped to choose my child's treatment goals.	1	2	3	4	5
4.	The people helping my child stuck with us no matter what.	1	2	3	4	5
5.	I felt my child had someone to talk to when he/she was troubled.	1	2	3	4	5
6.	I participated in my child's treatment.	1	2	3	4	5
7.	The services my child and/or family received were right for us.	1	2	3	4	5
8.	The location of services was convenient for us.	1	2	3	4	5
9.	Services were available at times that were convenient for us.	1	2	3	4	5

CHILD ID:

--	--	--	--	--	--	--	--

Youth Services Survey for Families, Abbreviated Version (YSS-F): Caregiver

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
10.	My family got the help we wanted for my child.	1	2	3	4	5
11.	My family got as much help as we needed for my child.	1	2	3	4	5
12.	Staff treated me with respect.	1	2	3	4	5
13.	Staff respected my family's religious/spiritual beliefs.	1	2	3	4	5
14.	Staff spoke with me in a way that I understood.	1	2	3	4	5
15.	Staff were sensitive to my cultural/ethnic background.	1	2	3	4	5
As a result of the services my child and/or family received:						
16.	My child is better at handling daily life.	1	2	3	4	5
17.	My child gets along better with family members.	1	2	3	4	5
18.	My child gets along better with friends and other people.	1	2	3	4	5
19.	My child is doing better in school and/or work.	1	2	3	4	5
20.	My child is better able to cope when things go wrong.	1	2	3	4	5
21.	I am satisfied with our family life right now.	1	2	3	4	5

22. **What has been the most helpful thing about the services your child received over the last 6 months?**

* Developed by Molly Brunk et al., 1999.

For all variables and data elements:

666 = Not Applicable
777 = Refused

888 = Don't Know
999 = Missing

Date last modified: 6/11/2004

YSS-F

CARD 1

1 = Strongly disagree

2 = Disagree

3 = Undecided

4 = Agree

5 = Strongly agree

This study is authorized by Section 565 of the Public Health Service Act. Public reporting burden for this collection of information is estimated to average 5 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0257); OAS; 1 Choke Cherry Road, Rockville, MD 20857.

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GAIN QUICK-R: SUBSTANCE PROBLEM SCALE (GAIN)

GQDATE (Today's Date)

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

CHILDDID (Macro-assigned ID)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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TIMEFRAM (Assessment Period)

- 1 = Intake
- 2 = 6 months
- 3 = 12 months
- 4 = 18 months
- 5 = 24 months
- 6 = 30 months
- 7 = 36 months

GQINTV (Who administered interview)

- 1 = Person providing services to child
- 2 = Data collector

GQMETH (Method of administering interview)

- 1 = In person, hard copy
- 2 = Telephone, hard copy
- 3 = In person, computer assisted
- 4 = Telephone, computer assisted

GQLANG (Language version of interview)

- 1 = English
- 2 = Spanish
- 3 = Other

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Now I'm going to ask you some questions about things that you may have done, felt, or had happen to you in the past 6 months as a result of using drugs or alcohol. We realize that this information is personal. Please remember that the answers you give will be kept private (*insert local confidentiality rules here*) and will never be linked to your name. For each question, answer "yes" or "no." As I'm reading a question, if I say something that applies to you, interrupt me and say "yes." You don't need to wait until I've read the whole question. I'll pause after each part of the question to give you a chance to answer. Some of the questions are long or have difficult words. Please let me know if you want me to repeat a question or explain what any of the words mean.

		Yes	No
1.	During the past 6 months, have you used any alcohol, marijuana, cocaine, heroin, or other substances?	1	0

[IF "NO," END OF QUESTIONNAIRE]

	During the past 6 months . . .		
1a.	have you tried to hide that you were using alcohol, marijuana or other drugs?	1	0
1b.	have your parents, family, partner, co-workers, classmates or friends complained about your alcohol, marijuana, or other drug use?	1	0
1c.	have you used alcohol, marijuana, or other drugs weekly?	1	0
1d.	has alcohol, marijuana, or other drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire, or caused other psychological problems?	1	0
1e.	has alcohol, marijuana, or other drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease, or any other health problems?	1	0

2.	During the past 6 months . . .		
2a.	have you kept using alcohol, marijuana, or other drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?	1	0
2b.	have you used alcohol, marijuana, or other drugs where it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or where you might have been forced into sex or hurt?	1	0
2c.	has alcohol, marijuana, or other drug use caused you to have repeated problems with the law?	1	0
2d.	have you kept using alcohol, marijuana, or other drugs even after you knew it could get you into fights or other kinds of legal trouble?	1	0

CHILD ID:

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GAIN Quick-R: Substance Problem Scale (GAIN)

		Yes	No
3.	During the past 6 months . . .		
3a.	have you needed more alcohol, marijuana, or other drugs to get the same high or found that the same amount did not get you as high as it used to?	1	0
3b.	have you had withdrawal problems from alcohol, marijuana, or other drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or have you used any alcohol, marijuana, or other drugs to stop being sick or avoid withdrawal problems?	1	0
3c.	have you used alcohol, marijuana, or other drugs in larger amounts, more often or for a longer time than you meant to?	1	0
3d.	have you been unable to cut down or stop using alcohol, marijuana, or other drugs?	1	0
3e.	have you spent a lot of time either getting alcohol, marijuana, or other drugs, using them, or feeling the effects of them (high, sick)?	1	0
3f.	has alcohol, marijuana, or other drugs caused you to give up, reduce, or have problems at important activities at work, school, home, or social events?	1	0
3g.	have you kept using alcohol, marijuana, or other drugs even after you knew it was causing or adding to medical, psychological, or emotional problems you were having?	1	0

For all variables and data elements:

 666 = Not Applicable
 777 = Refused

 888 = Don't Know
 999 = Missing

Appendix 12

Instrument Descriptions

I. Behavioral & Emotional Rating Scale–Parent Rating Scale (BERS–2C) and Behavioral & Emotional Rating Scale – Youth Rating Scale (BERS-2Y); 2nd Editions

- Identifies emotional and behavioral strengths of children
- Subscales include: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, Affective Strength, Career Strength,
- Caregivers rate behaviors as being *not at all like their child* to *very much like their child*
- Youth rate behaviors on a scale from *not at all like me* to *very much like me*
- 57 items, 10 minutes

- **Rationale**

- Will be used to assess the mental health variables of 1) reductions in symptoms, 2) increases in cognitive functioning, 3) positive goal directed behavior including increased purpose in life, 4) sense of self-efficacy, and 5) internal locus of control.

- **Reliability & Validity – BERS-2C**

- Several analyses reported in the BERS-2 Examiner's Manual, 2nd Edition indicated that the BERS-2C demonstrates adequate reliability. Coefficient alphas are reported for each BERS-2C subscale across 12 different age intervals in the BERS-2 Examiner's Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .80 to .93. The average for the Strength Index across the 12 age intervals was .97. Two studies reported in the BERS-2 Examiner's Manual, 2nd Edition examined the test-retest reliability of the BERS-2C. In the first study, test-retest correlation coefficients for the BERS-2C subscales ranged from .80 to .94. The coefficient for the Strength Index was .90. In the second study, test-retest correlation coefficients for the BERS-2C subscales ranged from .88 to .92, while the coefficient for the Strength Index was .87. All of these coefficients are in the very large range (Hopkins, 2002). Finally, interrater reliabilities between parent and student rating on each of the subscales ranged from .50 to .63, while the interrater reliability on the Strength Index as .54.

- Several analyses reported in the BERS-2 Examiner's Manual, 2nd Edition indicate that the BERS-2C demonstrates adequate validity. Concerning construct identification validity, confirmatory factor analysis supports the factor structure of the five core subscales used in calculating the Strength Index (Epstein, 2004). In addition, correlations between the BERS-2C standard scores and the Child Behavior Checklist (Achenbach & Rescorla, 2001) total problems score, broadband syndrome scores, narrow-band syndrome scores, competence scores and total competence score were in the expected direction, demonstrating criterion-prediction validity. Finally, correlations between the BERS-2C standard scores and the Total Social Skills scale of the Social Skills Rating System, Parent Form (Gresham & Elliot, 1990) were positive, while correlations between the BERS-2C standard scores and the Total Problem Behavior Scale of the Social Skills Rating System were negative. These correlations were in the hypothesized direction as well, further evidencing criterion-prediction validity.

- **Reliability & Validity – BERS-2Y**

- Several analyses reported in the BERS-2 Examiner's Manual, 2nd Edition indicated that the BERS-2Y demonstrates adequate reliability. Coefficient alphas are reported for each BERS-2Y subscale across six different age intervals in the BERS-2 Examiner's Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .79 to .88, while the average for the Strength Index across the six age intervals was .95. Test-retest correlation coefficients for the BERS-2Y subscales ranged from .84 to .91, while the coefficient for the Strength Index was .91. Finally, interrater reliabilities

between parent and student rating on each of the subscales ranged from .50 to .63, while the interrater reliability on the Strength Index as .54.

➤ Several analyses reported in the BERS-2 Examiner's Manual, 2nd Edition indicate that the BERS-2Y demonstrates adequate validity. Concerning construct identification validity, confirmatory factor analysis supports the factor structure of the five core subscales used in calculating the Strength Index (Epstein, 2004). In addition, correlations between the BERS-2Y standard scores and the Youth Self Report (Achenbach, 1991) total problems score, broadband syndrome scores, narrow-band syndrome scores, competence scores and total competence score were in the expected direction, demonstrating criterion-prediction validity. Finally, correlations between the BERS-2Y standard scores and the Total Social Skills scale of the Social Skills Rating System, Student Form (Gresham & Elliot, 1990) were in the hypothesized direction (i.e. positive), further evidencing criterion-prediction validity.

II. Child Behavior Checklist (CBCL)

- Standardized measure of children's symptomatology
- Caregivers' report of their child's problems, disabilities, and strengths
- Caregivers say how often statements describing behaviors are true for their child
- Scores: internalizing, externalizing, anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, aggressive behavior, total problems, activities competence, social competence, school competence, total competence
- 130 items, 20 minutes
- **Rationale**
 - Will be used to assess the mental health variables of 1) reductions in symptoms, 2) increases in cognitive functioning, and 3) reduction in suicidal behavior. It will also measure the changes in the frequency and amount of positive friendships (social support).
- **Reliability & Validity**
 - Achenbach and Rescorla (2001) have reported a variety of information regarding internal consistency, test-retest reliability, construct validity, and criterion-related validity. Good internal consistency was found for the Internalizing, Externalizing and Total Problems scales ($\alpha \geq .90$). The CBCL demonstrated good test-retest reliability after 8 days (Pearson r at or above .80 for all scales. Moderate to strong correlation with the Connor Parent Rating Scale –Revised and the Behavior Assessment System for Children (BASC) Scales (Pearson r coefficients ranged from .34 to .89) support the construct validity of the CBCL. The CBCL was, for most items and scales, capable of discriminating between children referred to clinics for needed mental health services and those youth not referred (Achenbach & Rescorla, 2001). A variety of other studies have also shown good criterion-related or discriminant validity (e.g., Barkley, 1998; McConaughy, 1993).
 - Inter-observer agreement was evident in a meta-analysis of 119 studies that used the CBCL. In 269 separate samples, statistically significant correlations (using Pearson r) were found among ratings completed by parents, mental health workers, teachers, peers, observers and adolescents themselves (Achenbach, McConaughy & Howell, 1987).
 - The instrument has been nationally normed on a proportionally representative sample of children across income and racial/ethnic groups. Racial/ethnic differences in total and subscale scores of the CBCL disappeared when controlling for socioeconomic status, suggesting a lack of instrument bias related to racial/ethnic differences.

III. GAIN Quick–R: Substance Problem Scale (GAIN)

- Assesses use, abuse and dependence of alcohol, marijuana or other drugs
- 16 questions, 5 minutes
- **Rationale**
 - Will be used to measure changes in alcohol and other drug abuse and dependence.
- **Reliability & Validity**
 - The overall alpha coefficient reported by Titus and Dennis (2004) for the 16 items of the GAIN for adolescents (using a 12 month timeframe) is .82. Two subscales result from the 16 core GAIN items: the nine-item Substance Use and Abuse Scale-9 (SUAS-9) and the seven item Substance Dependence Scale-7 (SDS-7). The alpha coefficients for these indices are .63 and .75, respectively.

IV. Youth Services Survey (YSS) & Youth Services Survey for Families (YSS-F)

- Measures perceptions of service across 5 domains: Access, Participation in treatment, Cultural sensitivity, Satisfaction, Outcomes
- 21 questions (1 open-ended), 5 minutes (youth and caregiver versions)
- **Rationale**
 - Will be used to measure satisfaction with the services in terms of participation and outcomes.
- **Reliability & Validity**
 - Based on reliability analysis of the State Indicator Pilot Project, which evaluated data from Colorado, Kentucky, Oklahoma, Texas, Virginia, and the District of Columbia, the Cronbach's alpha for the domain measuring access to services is .73, participation in treatment is .77, cultural sensitivity of staff is .91, satisfaction with services is .94 and perceived outcome of service is .91.

**Appendix 13:
Proposed Variables for Collection**

**Requested:
Invitation to Apply, Page 26**

- **From Page 26 of the Invitation to Apply:**
- **Variables:** Please describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. **Provide a copy in an indexed appendix to the application.** Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity, and appropriateness for use on the study population. Applicants must measure functional outcomes on participants across the categories listed below.

Demographic variables to be collected: date of birth, gender, race/ethnicity, youth's zip code, presenting problems, agencies the youth is involved with, funding sources and diagnosis.

Health Care: Medical diagnosis and treatment information will be collected through the MMIS database and tracked by the Plan Manager.

Community living: The living situation of study participants will be collected with the following detail: 1) days in PRTF, days in out-of-home placement, 2) days in home of choice, 3) days in psychiatric hospital, and 4) days in other out-of-home placement. These variables, along with the other demographic variables, will be collected upon intake for each youth in the study and will allow comparison by ethnicity/race, gender, age and other variables of interest.

School Functioning: The Plan Manager will have a close working relationship with the educational system and will collect the following variables at the end of each school term: 1) school attendance, 2) grade point average, and 3) number of disciplinary actions at school.

Juvenile Justice Outcomes: The ability to live successfully in the community is often a function of being able to avoid delinquent behavior and legal violations. The Plan Manager will record 1) the number of contacts with law enforcement personnel, 2) number of arrests and 3) number of convictions every six months.

Family Functioning: A key need if youth are to remain in the community and at home is a supportive family/caregiver. The Plan Manager must report any suspected abuse or neglect to the Child and Family Services Division. The Plan Manager will log any abuse and neglect reports.

Alcohol and Other Drug Use: Dual diagnosis of substance abuse and SED will be documented by the Plan Manager and monitored by measuring 1) decrease in alcohol and other drug use, and 2) decrease in exposure to alcohol and other drugs. This will be accomplished through the GAIN Quick R, which assesses use, abuse, and dependence of alcohol, marijuana, or other drugs. The overall alpha coefficient reported by Titus and Dennis (2004) for the 16 items of the GAIN for adolescents (using a 12 month timeframe) is .82; more information on reliability, validity and appropriateness and the GAIN tool are included in Appendix 12.

Mental health: The CBCL and the BERS-2Y will be used to measure 1) reductions in symptoms, 2) increases in cognitive functioning, 3) positive goal directed behavior including increased purpose in life, 4) sense of self-efficacy, 5) internal locus of control, and 6) reduction

Appendix 13

in suicidal behavior. The CBCL has good internal consistency and test-retest reliability. More information is included in Appendix XX. The BERS-2Y demonstrates adequate reliability, good test-retest correlation coefficients and inter-rater reliabilities between parent and students on each of six subscales. More information is included in Appendix 12.

Social support: Changes in the frequency and amount of positive friendships will be documented through the Social Competence Scale of the CBCL.

Program satisfaction: Family and child satisfaction. Wraparound child and family team satisfaction will be assessed with the Youth Services Survey, youth and caregiver versions (YSS & YSS-F). Collectively, these gauge satisfaction with services across domains (e.g., location, quality, cultural competency and participation in treatment). Based on a reliability analysis of the State Indicator Pilot Project, the Cronbach's alpha for the domain measuring access to services is .73, participation in treatment is .77, cultural sensitivity of staff is .91, satisfaction with services is .94 and perceived outcome of service is .91. More information is included in Appendix 12; the tool is included in Appendix 11.

Environmental variables: The family's ability to maintain stable housing, income and transportation will be assessed through an exit interview with the plan manager.

Appendix 14:
Identification, Recruitment and Retention Flow Chart

Referenced:
Part B Development Plan
Page 11

**Montana Medicaid Alternative To Residential Treatment
For Youth 6 To 16**

**SED DETERMINED BY MENTAL HEALTH THERAPIST - MENTAL HEALTH CENTER -
TARGETED CASE MANAGEMENT -VERIFIED BY DEPARTMENT REPRESENTATIVE**

AT RISK OF RTC PLACEMENT

**DEPARTMENT REPRESENTATIVE REVIEWS AND APPROVES INDIVIDUAL MEETS
CERTIFICATE OF NEED REQUIREMENTS FOR RTC PLACEMENT**

IF YES

NO - OUT OF GRANT

Client has right to
file appeal of decision
using Medicaid appeal
process

NO - OUT OF GRANT

**CHILD BEHAVIOR CHECKLIST
ASSESSMENT(CBCL) - RIGHT SCORE
(Plan Manager Coordinates CBCL)**

Parent selects to not participate - youth goes to RTC

YES - PARENT SELECTS TO PARTICIPATE

**PLAN MANAGER -
WORKS WITH PARENT TO ARRIVE AT TREATMENT PLAN AND COST OF
PLAN - SUBMITS PLAN TO CMHB FOR APPROVAL**

**PLAN MANAGER ARRANGES,
COORDINATES, AND MONITORS
SERVICES
COORDINATES WITH KMA
REVIEWS ELIGIBILITY @ 30 DAYS**

EXIT

**Parent opts out
\$ cap reached
Time cap reached
Level of service cap reached
Youth no longer meets project
criteria**

**Appendix 15:
Reporting Assurances**

Requested on Page 35 of the Invitation to Apply

Reporting Assurances: AMP Montana

Montana will cooperate with any Federal evaluation of the program and provide semi-annual (every 6 months) and final (at the end of the grant period) reports in a form prescribed by CMS (including the SF-269a “Financial Status Report” forms). Reports will be submitted electronically. These reports will outline how grant funds were used, describe program progress, and describe any barriers and measurable outcomes. Montana will provide information in the format that CMS requests for reporting and technical assistance necessary to complete required report forms. Montana will also agree to respond to requests that are necessary for the evaluation of the national efforts and provide data on key elements of their own grant activities.

Appendix 16:

Services in a PRTF are provided to individuals who are at an institutional level of care and such services must be a benefit under the State plan. States must ensure that such facilities comply with Federal statutory and regulatory specifications related to PRTFs at 42 CFR §440.160, § 441.151-152, and §483.352-.376. States that purchase the PRTF benefit from other State(s) are considered to be operating such a benefit under their State plan and are eligible for participation in this demonstration. As a part of a State's application to this demonstration, the State shall submit a copy of the pre-print page(s) indicating that such benefit is covered under the State's Medical Assistance Plan.

Requested: Invitation to Apply Pages 8 - 9

Note: The State Plan provides conditions for reimbursement of residential treatment. (Section 4.19D). This is supplemented by Montana Administrative Rule 37.88.1105, which specifies the criteria for participation in the Medicaid Program. Both are attached as part of this appendix.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

OMB-No. 0938-0193

State/Territory: Montana

Citation

2.7

Medicaid Furnished Out of State

431.52 and
1902(b) of the
Act, P.L. 99-272
(Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

RECEIVED
DEPT. OF HEALTH
HCFA/DHC-REG. VIII

TN NO. 87(10)1
Supersedes
TN NO. 82-19

Approval Date 1/23/87

Effective Date 10/1/86

HCFA ID:0053C/0061R

(a) maintain a current license as a residential treatment facility under the rules of the department's quality assurance division to provide residential psychiatric care, or, if the provider's facility is not located within the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the facility is located;

(b) maintain a current certification for Montana medicaid under the rules of the department's quality assurance division to provide residential psychiatric care or, if the provider's facility is not located within the state of Montana, meet the requirements of (g) and (h);

(c) for all providers, enter into and maintain a current provider enrollment form with the department's fiscal agent to provide residential treatment services;

(d) license and/or register facility personnel in accordance with applicable state and federal laws;

(e) accept, as payment in full for all operating and property costs, the amounts calculated and paid in accordance with the reimbursement method set forth in these rules;

(f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used only for those purposes for which the patient, legal guardian or personal representative of the patient has given written authorization. A provider may not borrow funds from these accounts for any purpose;

(g) maintain accreditation as a residential treatment facility by the joint commission on accreditation of health care organizations (JCAHO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit residential treatment facilities for medicaid participation;

(h) submit to the department prior to receiving initial reimbursement payments and thereafter within 30 days after receipt, all accreditation determinations, findings, reports and related documents issued by the accrediting organization to the provider;

(i) provide residential psychiatric care according to the service requirements for individuals under age 21 specified in Title 42 CFR, part 441, subpart D (October 1, 1992), which is a federal regulation which is herein incorporated by reference. A copy of these regulations may be obtained through the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210;

(j) agree to indemnify the department in the full amount of the state and federal shares of all medicaid residential treatment reimbursement paid to the facility during any period when federal financial participation is unavailable due to facility failure to meet the conditions of participation specified in these rules or due to other facility deficiencies or errors.

TN No. 96-019

Approval Date 01/31/97
Supersedes TN No. 95-015

Effective Date 04/01/96

(ii) Willing to furnish them to that particular recipient.

This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis.

(2) A recipient enrolled in a primary care case-management system, a Medicaid MCO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

(c) *Exceptions.* Paragraph (b) of this section does not prohibit the agency from—

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Subject to paragraph (b)(2) of this section, restricting recipients' free choice of providers in accordance with one or more of the exceptions set forth in §431.54, or under a waiver as provided in §431.55.

(d) *Certification requirement.* (1) *Content of certification.* If a State implements a project under one of the exceptions allowed under §431.54 (d), (e) or (f), it must certify to CMS that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met.

(2) *Timing of certification.* (i) For an exception under §431.54(d), the State may not institute the project until after it has submitted the certification and CMS has made the findings required under the Act, and so notified the State.

(ii) For exceptions under §431.54 (e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

[56 FR 8847, Mar. 1, 1991, as amended at 67 FR 41094, June 14, 2002]

§431.52 Payments for services furnished out of State.

(a) *Statutory basis.* Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) *Payment for services.* A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency;

(2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

(c) *Cooperation among States.* The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

§431.53 Assurance of transportation.

A State plan must—

(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

(b) Describe the methods that the agency will use to meet this requirement.

(Sec. 1902(a)(4) of the Act)

§431.54 Exceptions to certain State plan requirements.

(a) *Statutory basis.* Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a) (1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(b) *Additional services under a prepayment system.* If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to recipients who live in the area served by the organization and wish to obtain services from it.

(c) [Reserved]

(d) *Special procedures for purchase of medical devices and laboratory and X-ray tests.* The Medicaid agency may establish special procedures for the purchase of medical devices or laboratory and X-ray tests (as defined in §440.30 of this chapter) through a competitive bidding process or otherwise, if the State assures, in the certification required under §431.51(d), and CMS finds, as follows:

(1) Adequate services or devices are available to recipients under the special procedures.

(2) Laboratory services are furnished through laboratories that meet the following requirements:

(i) They are independent laboratories, or inpatient or outpatient hospital laboratories that provide services for individuals who are not hospital patients, or physician laboratories that process at least 100 specimens for other physicians during any calendar year.

(ii) They meet the requirements of subpart M of part 405 or part 482 of this chapter.

(iii) Laboratories that require an interstate license under 42 CFR part 74 are licensed by CMS or receive an exemption from the licensing requirement by the College of American Pathologists. (Hospital and physician laboratories may participate in competitive bidding only with regard to services to non-hospital patients and other physicians' patients, respectively.)

(3) Any laboratory from which a State purchases services under this section has no more than 75 percent of its charges based on services to Medicare beneficiaries and Medicaid recipients.